

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>16694</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div> <div>16707</div>											
1. DECEASED-NAME (Type or print) <b>Wayne</b> <b>Lee</b> <b>Ahern</b>						2a. DATE OF DEATH Month <b>Dec</b> Day <b>28</b> Year <b>68</b>			2b. HOUR <b>8:00</b> MIN <b>M</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Dec. 28, 1968</b>			6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS <b>10</b>
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.					
10. CITY OR TOWN OF DEATH <b>Frostburg</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Miners Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Westernport</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>157 Wood</b>		
14. FATHER'S NAME First <b>Harry</b> Middle <b>J</b> Last <b>Ahern</b>				15. MOTHER'S MAIDEN NAME First <b>Sandra</b> Middle <b>Duckworth</b> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT Address <b>Harry J. Ahern-Westernport, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immature birth</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Premature parturition (28 weeks)</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>776x</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 28, 1968</b> , to <b>Dec. 28, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 28, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>G. Paige Strong, M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>Dec. 28, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>A. Paige Strong</b>				22e. ADDRESS <b>Frostburg, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/30/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>			23d. LOCATION (City or Town) (County) (State) <b>Westernport Md.</b>				
24. FUNERAL DIRECTOR <b>E. J. Boral</b> ADDRESS <b>Westernport, Md. 21562</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>					

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Protonema (L.) (L.)  
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Protonema (L.) (L.)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MD. STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

16695

16708

1. DECEASED-NAME (Type or print) <b>Cora</b>			First Middle Last			2a. DATE OF DEATH Month <b>Dec.</b> Day <b>24</b> Year <b>68</b>			2b. HOUR <b>10:PM</b>		
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>7/1/83</b>			6. AGE (In years last birthday) <b>84</b> YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Allegany</b> Md.		
10. CITY OR TOWN OF DEATH <b>Cumberland</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Sylvan Retreat</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>			13c. CITY OR TOWN <b>Cumberland</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>313 Cecelia St.</b>			14. FATHER'S NAME First Middle Last <b>James Martin</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Barbara Mulligan</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Mrs. Florence Reed, Cumberland, Md. Niece</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute renal insufficiency approx. 1 wk</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic with mitral insufficiency many years</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>43002 mile Arteriosclerosis with mental deterioration</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>many years</b>	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>May 5, 1967</b> to <b>Dec. 24, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 24, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John K. Lippert M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									22c. DATE SIGNED <b>12-30-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>John K. Lippert M.D.</b>									22e. ADDRESS <b>Memorial Hospital Cumberland Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Dec. 27, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>		
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>JAN 2 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

18708

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Mr. Thomas M. Stanley, Secretary of the

U. S. Forest Service

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U. S. Forest Service

U. S. Forest Service

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16696

CERTIFICATE OF DEATH

16709

1. DECEASED-NAME (Type or print) <b>Preston</b>			First Middle Last			2a. DATE OF DEATH Month <b>Dec.</b> Day <b>24</b> Year <b>1968</b>			2b. HOUR <b>12 Noon</b>		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>Sept. 17, 1887</b>			6. AGE (In years lost birthday) <b>81</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>West Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Allegany</b> Md.		
10. CITY OR TOWN OF DEATH <b>Cumberland</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Sylvan Retreat</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Farmer (Ret.)</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>			13c. CITY OR TOWN <b>Cumberland</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>525 Fort Avenue</b>			14. FATHER'S NAME First Middle Last <b>Dice Bennett</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Emma Vint</b>			Address		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO. <b>236 58 0876</b>			17. INFORMANT <b>Mrs. Grace Price, Cumberland Md.</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Old A.S.H.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterio Sclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>many years</b> <b>many years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201 <b>Cerebral Arterio Sclerosis - mental deterioration</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 18, 1968</b> , to <b>Dec. 24, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John A. Topper M.D.</b>									22c. DATE SIGNED <b>12-30-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>John A. Topper M.D.</b>									22e. ADDRESS <b>Memorial Hospital Cumberland Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12/27/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>North Fork Mem. Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Riverton W. Va.</b>		
24. FUNERAL DIRECTOR <b>Byron Knight</b>			ADDRESS <b>Cumberland, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>JAN 2 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed from carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD. STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16697

16710

1. DECEASED-NAME (Type or print) JACK R. BLAIR			2a. DATE OF DEATH DEC Month 13 Day 68			2b. HOUR 350M					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 05-07-25		6. AGE (In years last birthday) 43 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY, Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, not retired) SUPERVISOR (FORESTRY)			12b. KIND OF BUSINESS OR INDUSTRY BOYS CAMP		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY Garrett			13c. CITY OR TOWN Lonaconing		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER (RURAL)	
14. FATHER'S NAME First Middle Last ROBERT BLAIR			15. MOTHER'S MAIDEN NAME First Middle Last (STEVENSON) MARY BLAIR								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) YES			16b. SOCIAL SECURITY NO. 218-16-4680			17. INFORMANT Address MD. 21502 SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from 8-5-1968, to 8-9-1968, that (1) (we) last saw the deceased alive on 8-9-1968, and that in (2) (my) (our) opinion death occurred on the date and hour and from the causes stated above (3) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Matthew Kaufman									22c. DATE SIGNED 12-13-68		
22d. PHYSICIAN'S NAME (Type) MATTHEW KAUFMAN, M.D.									22e. ADDRESS 912 SETON DR., CUMB., MD. 21502		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 12/15/1968			23c. NAME OF CEMETERY OR CREMATORY Memorial Park			23d. LOCATION (City or Town) (County) (State) Frostburg, Md.		
24. FUNERAL DIRECTOR ADDRESS EICHORN FUNERAL SERVICE, 8 E. MAIN ST., LONA						25a. REC'D BY REGISTRAR DATE DEC 16 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

MATTHEW R. ICHORN, D.D.

212 SETON DR., CUBA, N.E. 68102

YES

ROBERT

BLAIR

(STEVENSON) MARY

BLAIR

212-16-4800 SACRED HEART HOSPITAL, AND SETON DR., CUBA, NE 68102

CORRECTION

SACRED HEART HOSPITAL

SUPERIOR (HOLY) BOYS CAMP

MARYLAND

U.S.A.

ALLEGANY COUNTY,

FILE

WHITE

03-07-52

UICR

BLAIR M.

**FOR STATE  
HEALTH DEPT.**

any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 14-3. Page 5 may be retained for your files.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16698

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

16711

1. DECEASED-NAME (Type or Print)			First Robert	Middle Fulton	Last Boden	2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Dec. 25, 1968			2b. HOUR 11:00 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Jan. 25, 1898	6. AGE (In years last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day 30, Year 19 68		2d. HOUR 11:30 A.M.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.				
10. CITY OR TOWN OF DEATH Cumberland.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 324 Beall St.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bus driver			12b. KIND OF BUSINESS OR INDUSTRY Welfare Organization	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 324 Beall St.		
14. FATHER'S NAME First Middle Last Joseph D. Boden			15. MOTHER'S MAIDEN NAME First Middle Last Julia -- Hartley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes, U.S. # 162			16b. SOCIAL SECURITY NO. 214-07-0247		17. INFORMANT ADDRESS Mr. Douglas M. Boden 323 Avirett Ave. Cumb. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN ---										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion										
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>			M.D. BENEDICT SKITARELIC, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED Dec. 30, 1968		
EXAMINER'S NAME (Type)			ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/1/69		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park.			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.			
24. FUNERAL DIRECTOR H. Wayne George 202 Greene St. Cumb. Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE JAN 6 1969		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

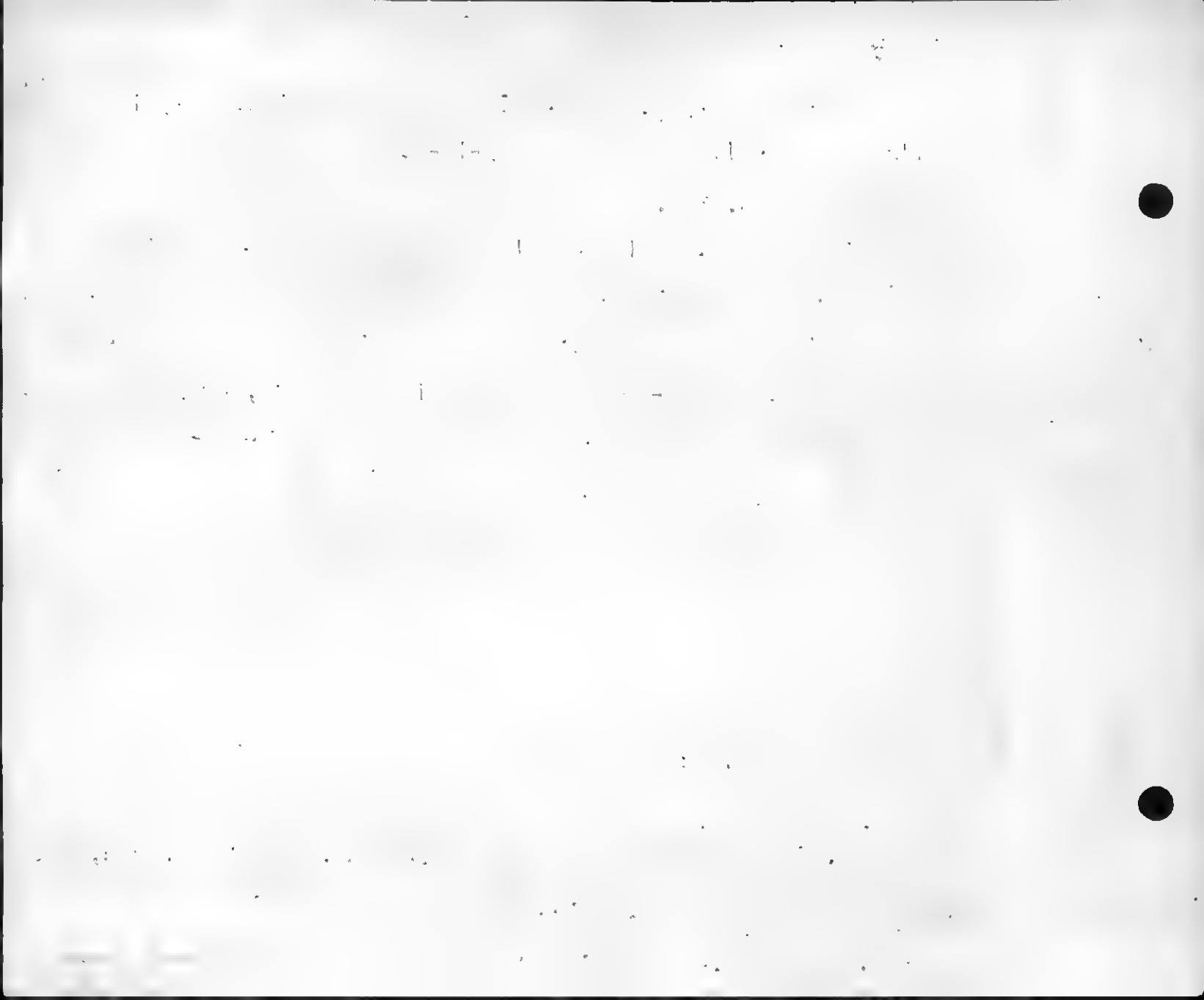
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1 DECEASED NAME (Type or print) <b>LESTER Sylvester BOGGS</b>			2a DATE OF DEATH <b>DECEMBER 29, 1968</b>		2b HOUR <b>11:05</b>
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>9-14-06</b>		6 AGE (In years last birthday) <b>62</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>ALLEGANY</b> Md.		
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a USJA. OCCUPATION (Kind of work done during most of work no life, even if retired) <b>FREIGHT STEWARD CLERK</b>	
12b KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>		13a USJA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b COUNTY <b>ALLEGANY</b>	
13c CITY OR TOWN <b>CUMBERLAND</b>		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <b>307 JEFFERSON ST.</b>	
14 FATHER'S NAME First Middle Last <b>HARRY BOGGS</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>NANCY CRABTREE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>YES WW 2</b>		16b SOCIAL SECURITY NO <b>705-10-7916</b>		17 INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leukemic Lymphatic Leukemia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Cardiac Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>1047</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr - 5 mo</b> <b>4 hr</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>2</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21f LOCATION Street or R.F.D. No. City or Town County State	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 19 <b>67</b> , to <b>Dec 29</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Dec 29</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>Clay Durrett</b>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <b>12/30/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>DR. CLAY DURRETT</b>		22e ADDRESS <b>236 VA. AVE., CUMBERLAND, MD.</b>			
23a BURIAL, CREMATION, REMAINS (Specify) <b>BURIAL</b>		23b DATE <b>1/1/1969</b>		23c NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	
23d LOCATION (City or Town) (County) (State) <b>Near Cumberland Alleg Md</b>		23e REC'D BY REGISTRAR <b>Charles E. Hafer</b>			
24. FUNERAL DIRECTOR <b>Charles E. Hafer</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR		
LEONA			MARGARET			BONE			Month 12 Day 21 Year 68 1:58 PM		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)		
FEMALE			WHITE			2-19-05			63 YRS		
7a BIRTHPLACE (State or foreign country)			7b CIT ZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
MARYLAND			USA						ALLEGANY Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			SACRED HEART HOSPITAL			HOUSEWIFE					
13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d STATE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND			ALLEGANY			FROSTBURG			13e STREET AND NUMBER 151 PARK AVENUE		
14 FATHER'S NAME First Middle Last			15 MOTHER'S M A D E N NAME First Middle Last								
JAMES			WARNICK			GROVE			RHODA WARNICK		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT			SACRED HEART HOSPITAL 900 SETON DR., CUMB., MD		
NO			214-07-6213			HOSPITAL RECORDS					
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>										16 hrs.	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										yes	
(b) <u>Hypertension</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			19 P.M.								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/19, 1968</u> to <u>12/21, 1968</u> , that (I) (we) last saw the deceased alive on <u>12/20, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death											
22b SIGNATURE											
<u>[Signature]</u>											
22c DATE SIGNED <u>12/21/68</u>											
22d PHYSICIAN'S NAME (Type) <u>J. A. PAGAN, M.D.</u>											
22e ADDRESS <u>1068 NATIONAL HIGHWAY, LAVALE, MD.</u>											
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
<u>BURIAL</u>			<u>12-24-68</u>			<u>FBI MEMORIAL PARK</u>			<u>FROSTBURG MD</u>		
24 FUNERAL DIRECTOR <u>DURST FRNERAL HOME, FROSTBURG, MD.</u>											
25a. REC'D BY REGISTRAR <u>DEC 27 1968</u>											
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>											

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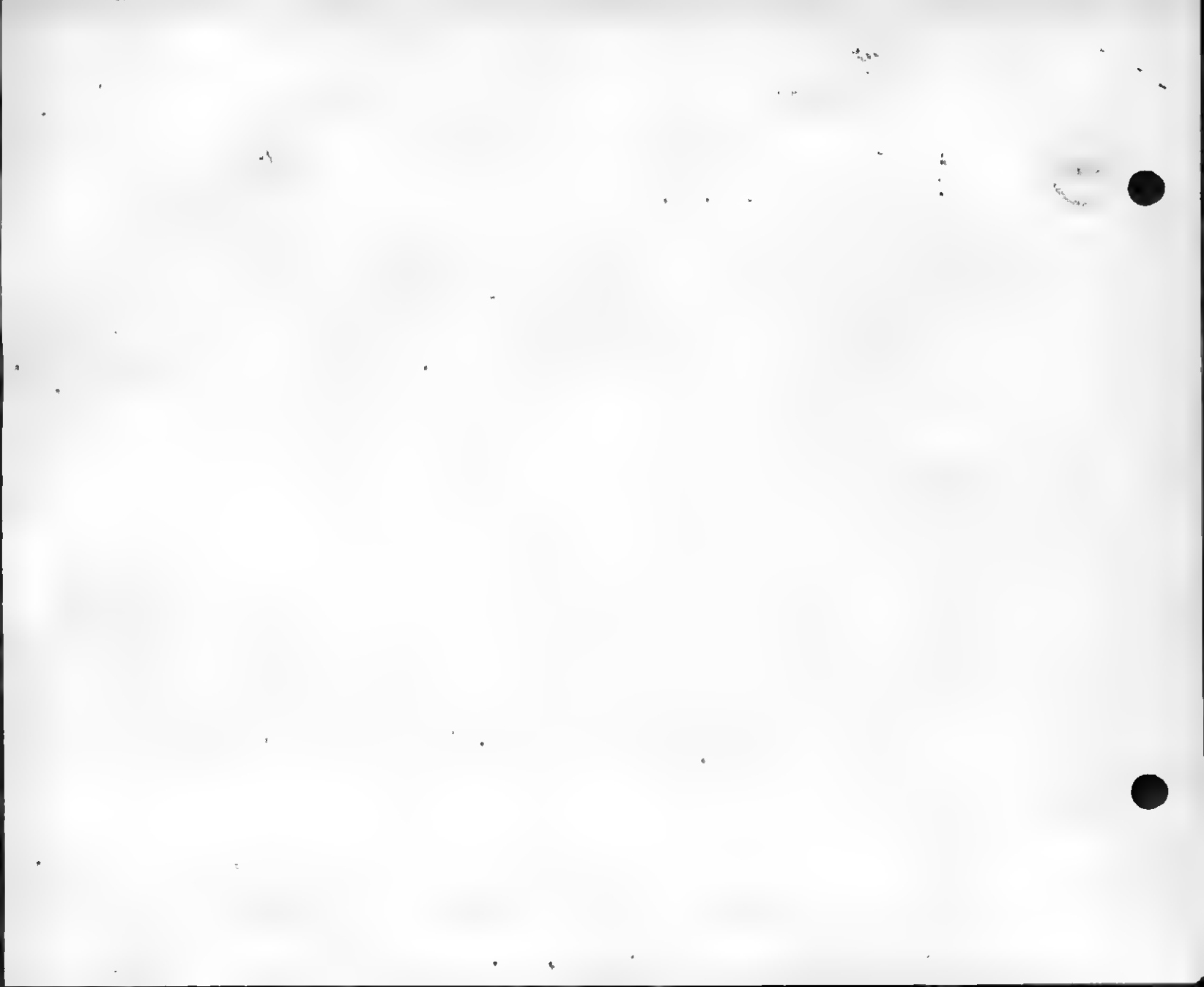
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH at 7:45 P.M. December 19, 1968		2b. HOUR P. M.	
Cornelius		J.		Broadwater							
3. SEX Male		4. RACE white		5. DATE OF BIRTH 12/25/1892		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany County Md.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Coal Miner		12b. KIND OF BUSINESS OR INDUSTRY Coal Mining					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Barton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Route #1			
14. FATHER'S NAME First Kennard		Middle Broadwater		Last Broadwater		15. MOTHER'S MAIDEN NAME First Anna		Middle Wiland		Last Wiland	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT P.O. Box 599, Allegany County Infirmary records. Address: Cumberland, Md.					
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD - congestive heart failure 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary emphysema DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma Prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Nov. 13, 1968, to Dec. 19, 1968, that (I) (we) last saw the deceased alive on Dec. 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE George M. Moore M.D. DEGREE		22c. DATE SIGNED		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Memorial Hospital, Cumberland, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/22/68		23c. NAME OF CEMETERY OR CREMATORY Greens Cemetery		23d. LOCATION (City or Town) Lonaconing		(County) Garrett		(State) Md	
24. FUNERAL DIRECTOR George Eichhorn		ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR DEC 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



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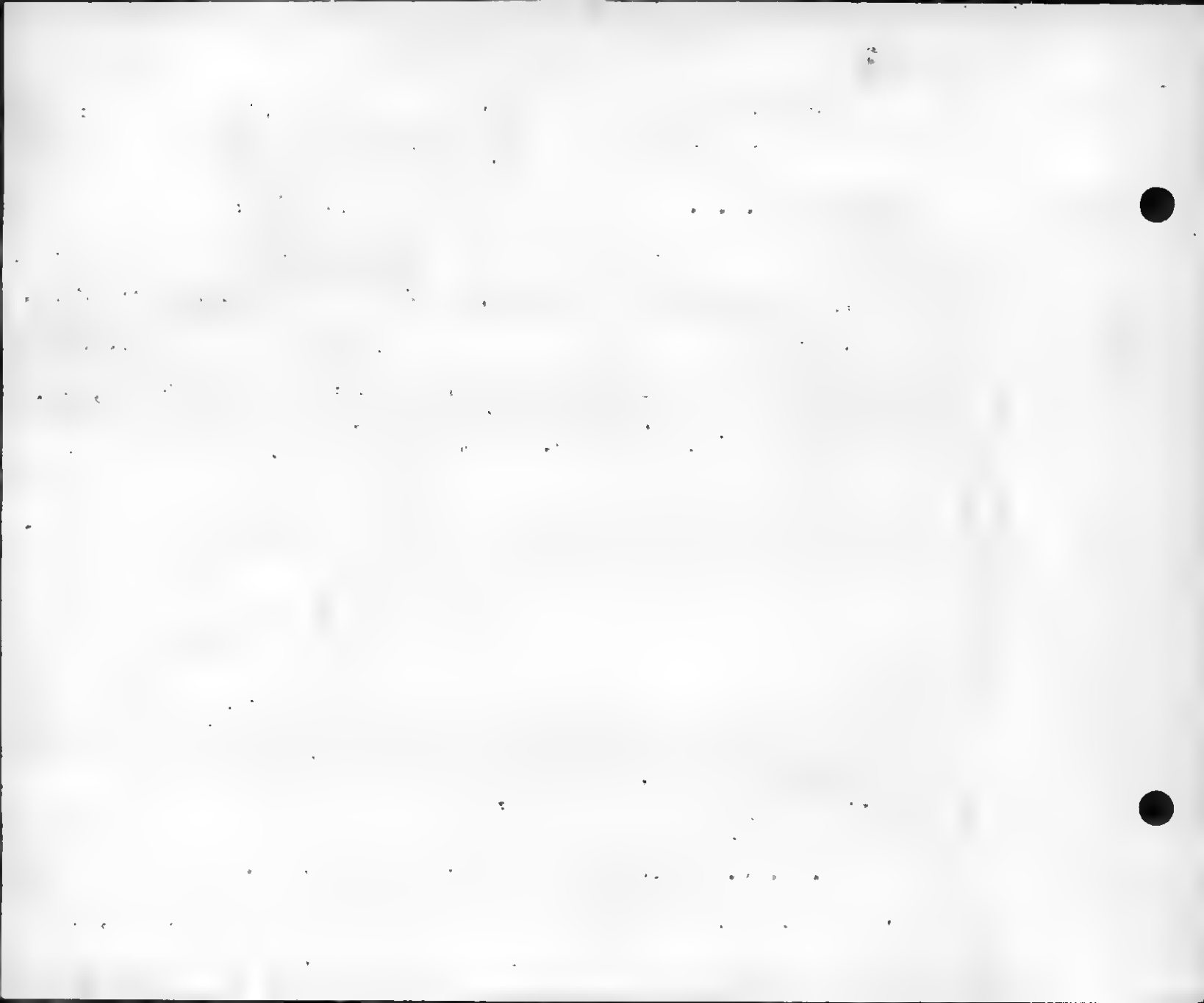
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30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16715

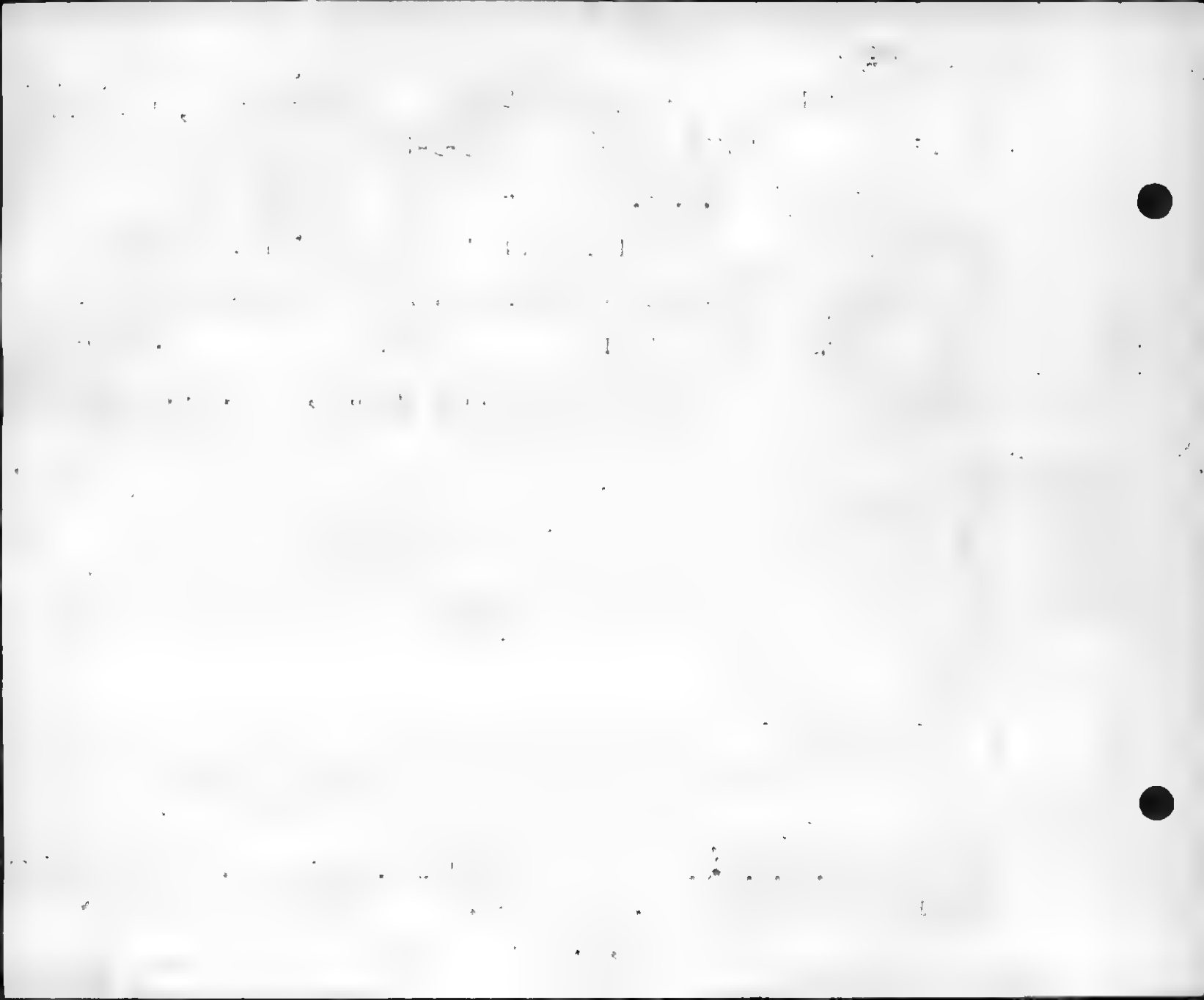
1. DECEASED-NAME (Type or print) <b>GRAYSON</b>		First <b>S</b>		Middle <b>BURKE</b>		Last <b>BURKE</b>		2a. DATE OF DEATH Month <b>12</b> -Day <b>24</b> -Year <b>88</b>		2b. HOUR <b>8:05A</b> M	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>1-23-02</b>		6. AGE (in years last birthday) <b>66</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md					
1d. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Carman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>900 REAR OLDTOWN RD.</b>			
14. FATHER'S NAME First <b>SAMUEL</b>		Middle <b>BURKE</b>		Last <b>BURKE</b>		15. MOTHER'S MAIDEN NAME First <b>VALLIE</b>		Middle <b>COFFMAN</b>		Last <b>COFFMAN</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>705-05-4550</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Diabetes Mellitus &amp; Complications</b> <b>2509</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ P.M. _____ Month _____ Day _____ Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) _____							
21d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. _____		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ <b>Cumberland, Md.</b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>12/24/87</b> , 19____, to <b>12/24/87</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>DR. R. J. WILLIAMS</b>		DEGREE _____		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/24/87</b>	
22d. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>		22e. ADDRESS <b>CUMBERLAND, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 28, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>					
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		ADDRESS _____		25a. REC'D BY REGISTRAR DATE <b>JAN 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



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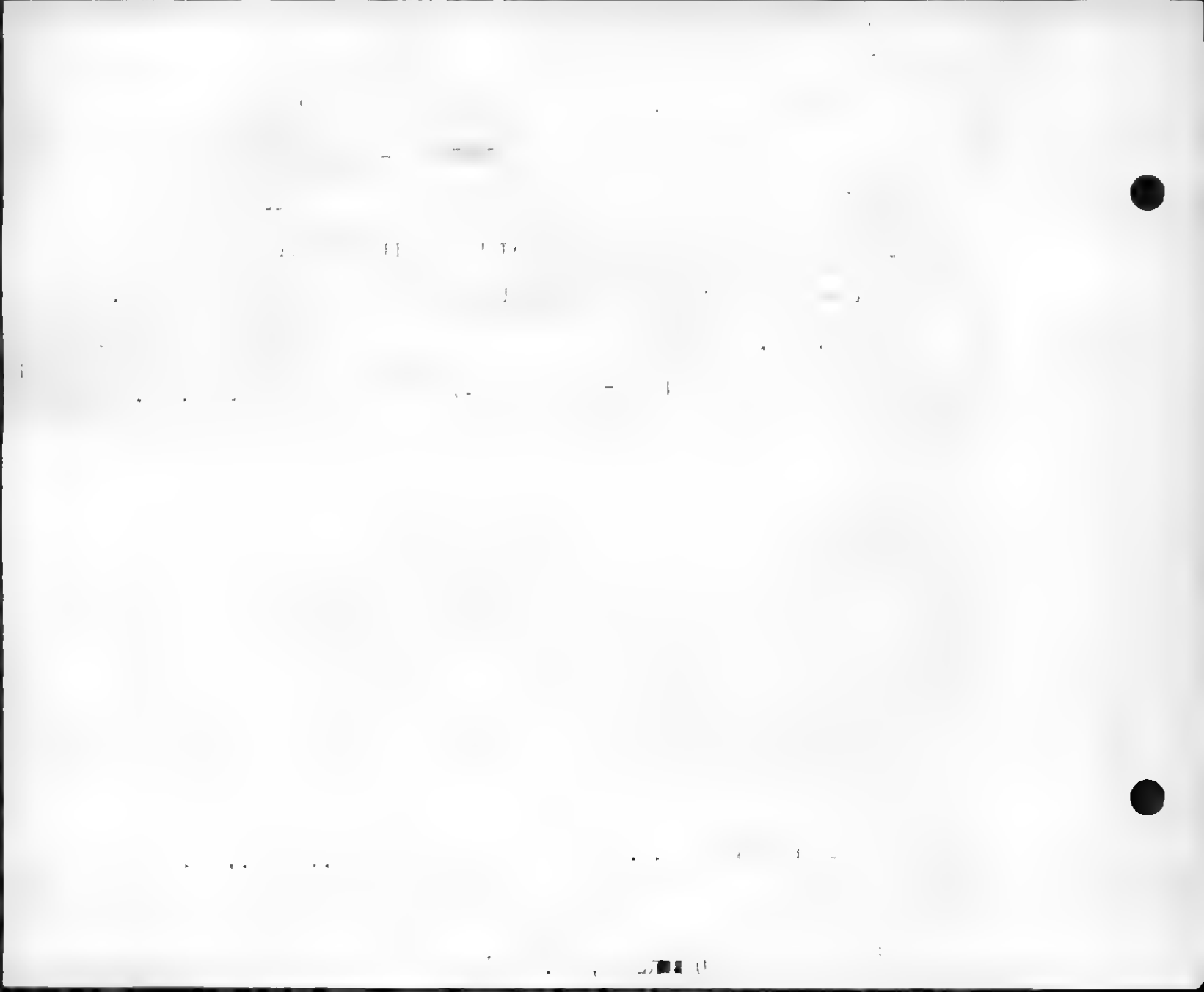
MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print)		First <b>MARIA</b>		Middle		Last <b>CAVALLARO</b>		2a DATE OF DEATH Month Day Year <b>DECEMBER 24, 1968</b>		2b HOUR <b>2:55 PM</b>			
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>5-5-1889</b>		6 AGE (In years last birthday) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>ITALY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>		8- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>ALLEGANY</b> Md.							
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of last year) <b>HOUSEWIFE (retired)</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>ALLEGANY</b>			13c. CITY OR TOWN <b>WESTERNPORT</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER <b>213 MARYLAND AVE</b>	
14. FATHER'S NAME First Middle Last <b>JOHN LUPIS</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>TERESA ALVARO</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>no</b>				16b. SOCIAL SECURITY NO.		17 INFORMANT Address <b>MEMORIAL HOSPITAL, CUMB. MD.</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <b>674X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1041 No</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>13 Dec</u> , 1968, to <u>24 Dec</u> , 1968, that (I) (we) last saw the deceased alive on <u>24 Dec</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>Dr. Van C. Miller at hosp pronounced pt dead</u>													
22b. SIGNATURE <u>Mark M. Kroll M.D.</u> M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED <b>26 Dec 68</b>													
22d. PHYSICIAN'S NAME (Type) <b>MARK M. KROLL</b> <b>DR. XXXXXXXX</b>						22e. ADDRESS <b>110 122X S. CENTRE ST., CUMBERLAND, MD</b>							
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Buried</b>		23b. DATE <b>12/28/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cem.</b>		23d. LOCATION (City or town) (County) (State) <b>Westernport Allegany Md.</b>							
24. FUNERAL DIRECTOR <u>W. J. B. B. B.</u> ADDRESS <b>Westernport, Md. 21562</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 30 1968</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

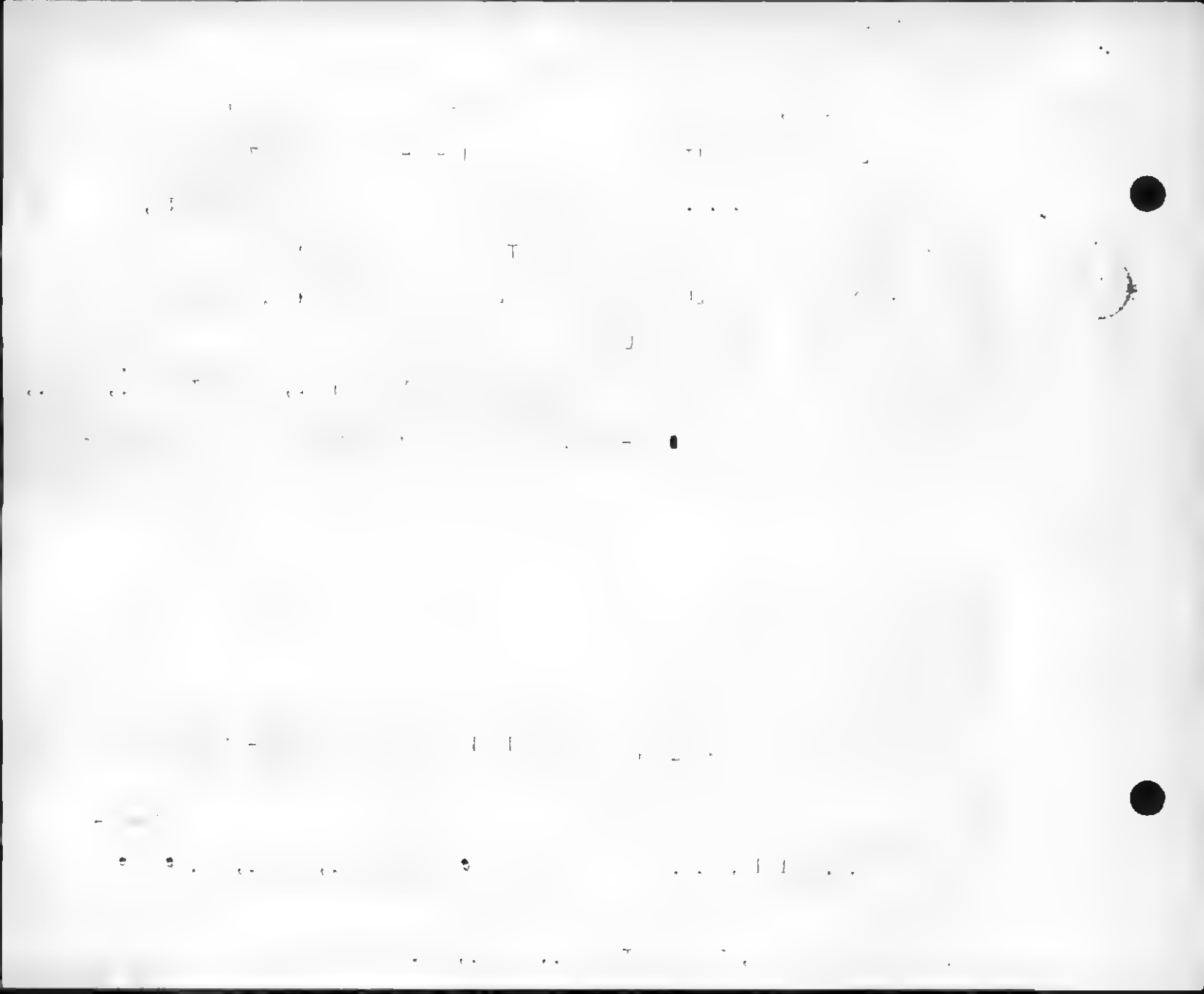
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>MARIE</b>			First <b>C.</b> Middle <b>CHAMBERS</b> Last			2a. DATE OF DEATH <b>DECEMBER 4, 1968</b>		2b. HOUR <b>M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>4-28-1904</b>		6. AGE (In years last birthday) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md			
1d. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>PICKET SELLER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MOVIE</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>133 SO LIBERTY ST.</b>	
14. FATHER'S NAME First <b>FREDERICK E.</b> Middle <b>KORNHOF</b> Last				15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>ELIZABETH</b> Last <b>CASPERLINE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>213-22-3384</b>		17. INFORMANT <b>SACRED HEART HOSPITAL</b> Address <b>900 SETON DRIVE</b> <b>HOSP., CHART</b> <b>CUMBERLAND, MD. 21502</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> <b>41-7</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>coronary sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b> <b>1 month</b> <b>1 year</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 2 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BLDG. ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (th's hospital) attended the deceased from <u>11-9-</u> , 19 <u>68</u> , to <u>12-4-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-4-</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>L. Brings</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>12-5-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS, M.D.</b>				22e. ADDRESS <b>57 GREENE ST., CUMB., MD. 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12/7/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>			
24. FUNERAL DIRECTOR <b>SILCOX FUNERAL HOME</b>				ADDRESS <b>404 DECATUR ST.</b>		25a. REC'D BY REGISTRAR <b>DEC 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
				<b>CUMBERLAND, MD. 21502</b>					



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16705		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		16718	
Item 3 Film 0407 12/23/68 kk					
1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year
CLARK,		MARY	FRANCES		12 11 68
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday) YRS
FEMALE	WHITE		10-08-98		70
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH
WEST VIRGINIA	U.S.A.				ALLEGANY COUNTY, Md.
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)	
CUMBERLAND		SACRED HEART HOSPITAL		HOUSEWIFE	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN	
MARYLAND		ALLEGANY		CUMBERLAND	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		12b KIND OF BUSINESS OR INDUSTRY	
		111 N. PAW PAW WAY		Own Home	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME			
First Middle Last		First Middle Last			
CHARLES		WELCH		WELCH	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT Address	
NO		215-20-5501		MD. 21502	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ADENO-CARCINOMA OF UTERINE CERVIX</b>					6 MOS
180X DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
111X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No. City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from 12 5, 19 68, to 12 - 11, 19 68, that (I) (we) last saw the deceased alive on 12 - 11 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE				22c DATE SIGNED	
R.W. BALLIN, M.D.				12-11-68	
22d. PHYSICIAN'S NAME (Type)				22e ADDRESS	
R.W. BALLIN, M.D.				62 GREENE ST., CUMB., MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		12/13/68		I. O. O. F. Cemetery	
24 FUNERAL DIRECTOR		23d LOCATION (City or Town) (County) (State)		23e RECORD BY REGISTRAR	
KIGHT FUNERAL HOME, 309 DECATUR ST., CUMB.,		Elk Garden		DEC 16 1968	
25a		25b REGISTRAR'S SIGNATURE		25c	
		J. Charles Judge			



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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

16708

16719

1. DECEASED-NAME (Type or print)		First <b>NERINE</b>	Middle <b>R.</b>	Last <b>CONROY</b>	2a. DATE OF DEATH Month <b>12</b> Day <b>22</b> Year <b>68</b>		2b. HOUR <b>9:28</b> P M
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>01-22-07</b>		6. AGE (in years last birthday) <b>61</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HWF</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>WILLIAM</b>		Middle <b>MORRISON</b>		Last <b>EVA</b>		15. MOTHER'S MAIDEN NAME First <b>ROSS</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>PTS. HOSPITAL CHART</b>		Address <b>900 SETON DRIVE CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> <b>4309</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>ruptured berry aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>stroke</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19__		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Clarence J. Vincent M.D.</u>				DEGREE <b>ATTENDING PHYS</b> <input checked="" type="checkbox"/> <b>MED DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS</b> <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>CLARENCE VINCENT, M.D.</b>				22e. ADDRESS <b>912 SETON DRIVE CUMB., MD. 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>DEC. 26, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND, MD.</b>	
24. FUNERAL DIRECTOR <b>KIGHT FUNERAL HOME</b>				ADDRESS <b>309 DECATUR ST. CUMBERLAND, MD. 21502</b>		25a. REC'D BY REGISTRAR <b>DEC 30 1968</b>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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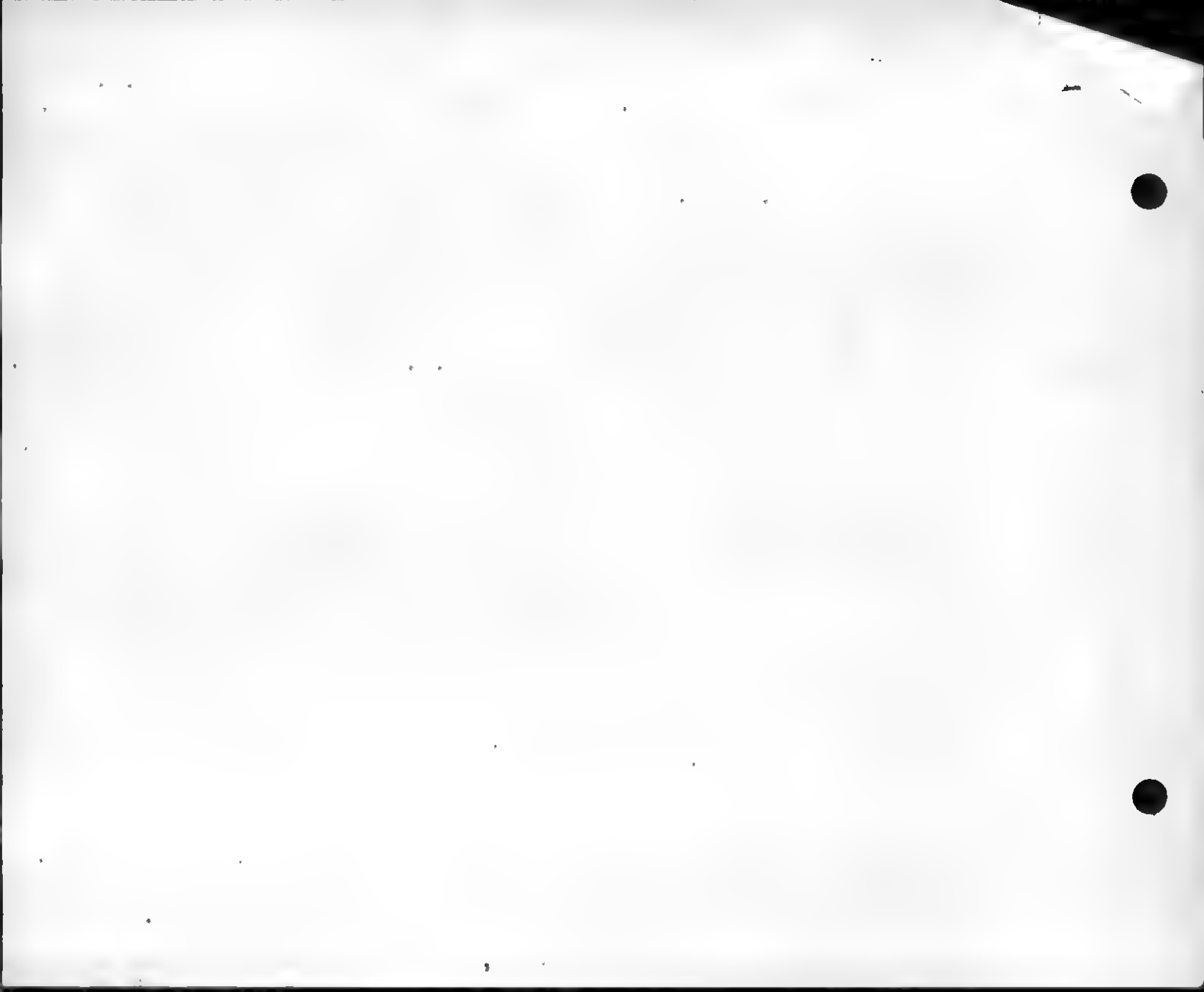
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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR				
Russell			W. Cutter			at 6:35 P.M. December 24, 1968			P. M.				
3. SEX		4. RACE		5 DATE OF BIRTH			6 AGE (in years last birthday)		7 UNDER 1 YEAR		7 UNDER 24 HRS.		
Male		White		May 15, 1893			75 YRS.		MONTHS DAYS		HOURS M.N.		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Maryland			U. S. A.						Allegany County			Md.	
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
Cumberland				Allegany County Infirmary				Retired; Celanese				Celanese	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland				Allegany		Midland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
First Middle Last				First Middle Last									
Jacob Cutter				Lanna Poland									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b SOCIAL SECURITY NO		17. INFORMANT P.O. Box 599, Allegany County Infirmary records.							
						Address: Cumberland, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY.													
IMMEDIATE CAUSE (a) Acute renal insufficiency													
41-29 DUE TO, OR AS A CONSEQUENCE OF													
(b) Cholelithiasis													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Arteriosclerosis													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Small cerebral A.S. with minimal deterioration													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, or office, building, etc.)				21f LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Oct. 9, 1968 to Dec. 24, 1968, that (I) (we) last saw the deceased alive on Dec. 24, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death													
22b SIGNATURE													
John A. Tupper M.D.													
22d. PHYSICIAN'S NAME (Type)													
John A. Tupper M.D.													
22e ADDRESS													
Memorial Hospital, Cumberland, Md.													
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
Burial				12/28/68		Sunset Memorial Park				Cumberland A. Md			
24. FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
George Eichhorn				Lonaconing, Md.				DATE DEC 31 1968		John Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16708

CERTIFICATE OF DEATH

16721

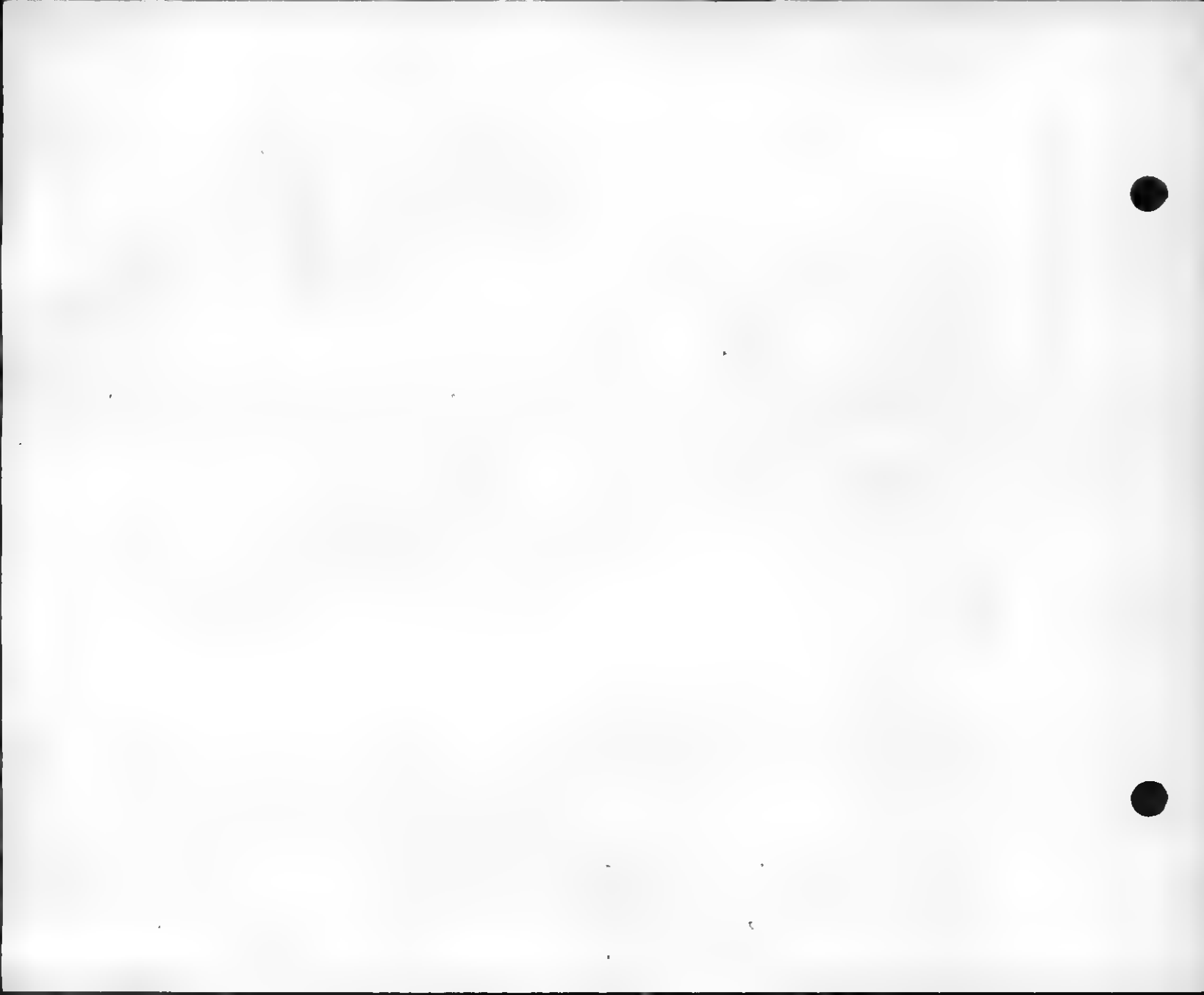
1 DECEASED NAME (Type or print) <b>CORA</b>		First <b>M.</b>		Last <b>DAVIS</b>		2a. DATE OF DEATH Month <b>9</b> Day <b>1968</b>		2b. HOUR <b>6:25A</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>08-06-1986</b>		6. AGE (In years last birthday) <b>82</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>		Md	
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSP.</b>		12a. USUAL OCCUPATION (Kind of work done during most of last year) (If retired) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RT. 4 BOX 218</b>	
14 FATHER'S NAME First <b>CHARLES</b>		Middle <b></b>		Last <b>HOUSE</b>		15 MOTHER'S MAIDEN NAME First <b>RUTH</b>		Middle <b>E.</b> Last <b>PIPER</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO <b>220-118-2359-11</b>		17 INFORMANT <b>MEMORIAL HOSP., CUMBERLAND, MD.</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Viral Influenza</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Coronary Insufficiency</b> (c) <b>Arteriosclerotic Cardiovascular Disease</b> years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>1 week</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic Atrial Fibrillation</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19 <b></b> , to <b>Dec.</b> , 19 <b>68</b> , that (I) <b>last</b> saw the deceased alive on <b>Dec. 9</b> , 19 <b>68</b> and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>was (did) (did not)</b> view the body after death.									
22b. SIGNATURE 		DEGREE <b>M.D.</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>12-9-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>G. OVERTON HIMMELWRIGHT M.D.</b>		22e. ADDRESS <b>133 VA. AVE., CUMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>DEC 11 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DAVIS MEMORIAL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>RFD# 1 CUMBERLAND ALLEGANY MD.</b>			
24 FUNERAL DIRECTOR <b>H. LEE SILCOX</b>		ADDRESS <b>404 DECATUR ST CUMBERLAND MD.</b>		25a. REC'D BY REGISTRAR <b>DEC 12 1968</b>		25b. REGISTRAR'S SIGNATURE 			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove for your papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
16708 CERTIFICATE OF DEATH 16722												
1. DECEASED NAME (Type or print)			First DELLA		Middle W.		Last DAVIS		2a. DATE OF DEATH DEC. Month 3 Day 1968 Year		2b. HOUR 9A M	
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH AUG. 7, 1884			6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH FROSTBURG			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WORK			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN VALE SUMMIT			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last JOHN S. CARR			15. MOTHER'S MAIDEN NAME First Middle Last ELIZABETH MATTHEWS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT Address LLOYD F. DAVIS, RT. 1, FROSTBURG, MD. 21532						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>174X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>age</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>77</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. cal. examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>11/20, 1968</u> , to <u>12/3, 1968</u> , that (I) (we) last saw the deceased alive on <u>12/3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>John B. Davis</u>			22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.			22d. ADDRESS 2 BROADWAY, FROSTBURG, MD. 21532			22e. DATE SIGNED 12/5/68			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE DEC. 6, 1968			23c. NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK			23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.			
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD.			25a. REC'D BY REGISTRAR DATE DEC 9 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						

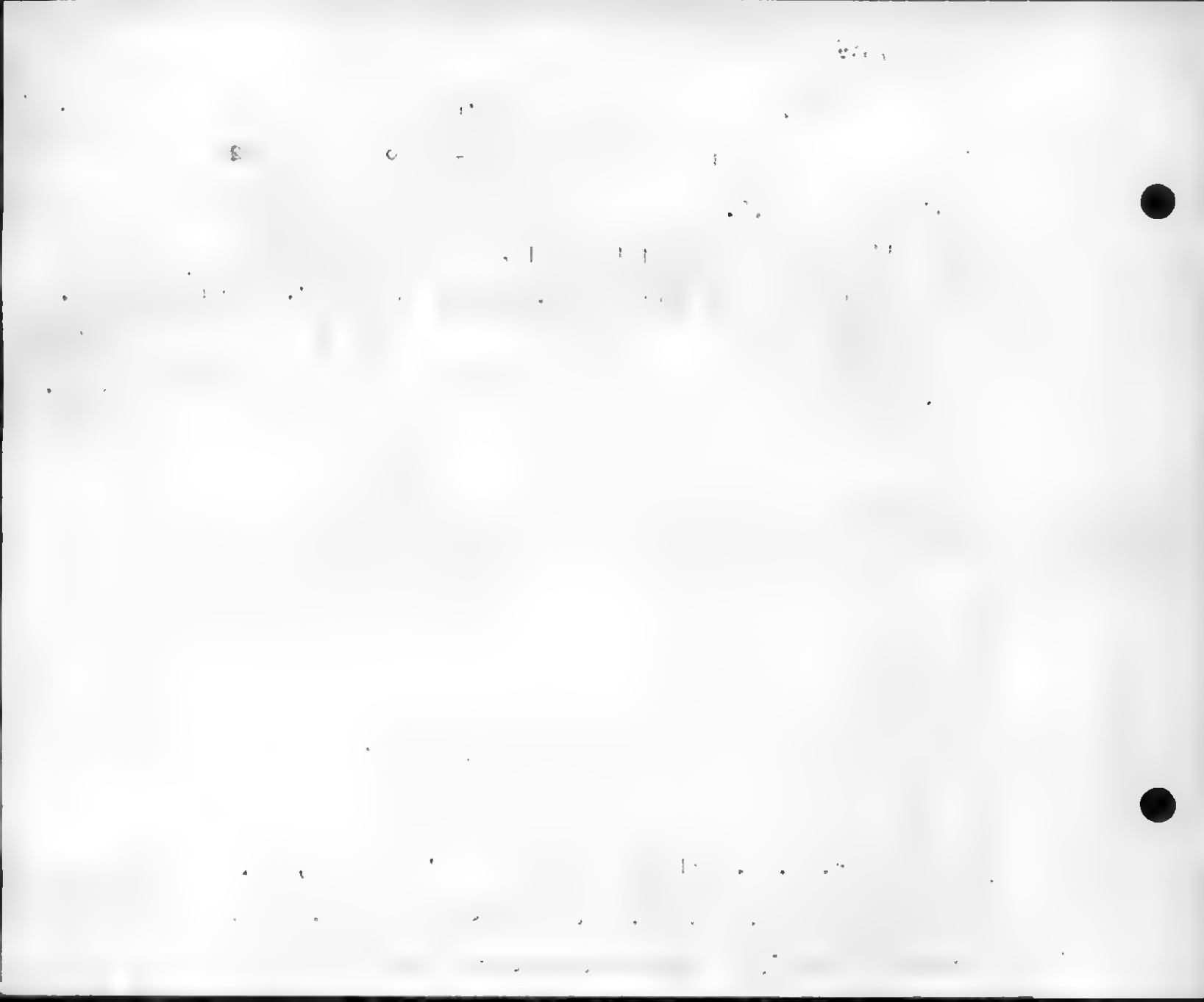


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please removeendor papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

<div style="text-align: center;"> <div>16710 18710</div> <div> <div>1</div> <div>16723</div> </div> </div> <div style="text-align: center;"> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> </div>																	
1. DECEASED NAME (Type or print)			First <b>DOROTHY</b>			Middle <b>P</b>			Last <b>DAVIS</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>5</b> Year <b>68</b>			2b. HOUR P <b>12:45 M</b>		
3 SEX <b>FEMALE</b>			4 RACE <b>WHITE</b>			5. DATE OF BIRTH <b>4-27-06</b>			6. AGE (In years last birthday) <b>62</b> YRS.			IF UNDER 1 YEAR MONTHS <b>62</b>			IF UNDER 24 HRS. HOURS <b>12</b> MIN <b>45</b>		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ALLEGANY</b>			Md					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>ALLEGANY</b>			13c. CITY OR TOWN <b>CUMBERLAND</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>315 SPRINGDALE ST.</b>					
14. FATHER'S NAME First <b>JAMES</b>			Middle <b>GORDON</b>			Last <b>MOLLIE</b>			15. MOTHER'S MAIDEN NAME First <b>MOLLIE</b>			Middle <b>MORGAN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>MEMORIAL HOSPITAL</b>			Address <b>CUMBERLAND, MD.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart Disease - Rheumatic and</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>2 years</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>10/8</u> , 19 <u>68</u> , to <u>12/5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/5</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>S. G. Weisman</u>			DEGREE <b>DR. S. G. WEISMAN</b>			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <u>12/6/68</u>								
22d. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>			22e. ADDRESS <b>CUMBERLAND, MD.</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Dec. 8, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Savage Methodist Cem</b>			23d. LOCATION (City or Town) (County) (State) <b>Mt. Savage Alleg Md</b>								
24. FUNERAL DIRECTOR <u>Charles E. Hafer</u>			ADDRESS <b>Charles E. Hafer, 230 Balto Ave. Cumberland Md</b>			25a. REC'D BY REGISTRAR <b>DEC 10 1968</b>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

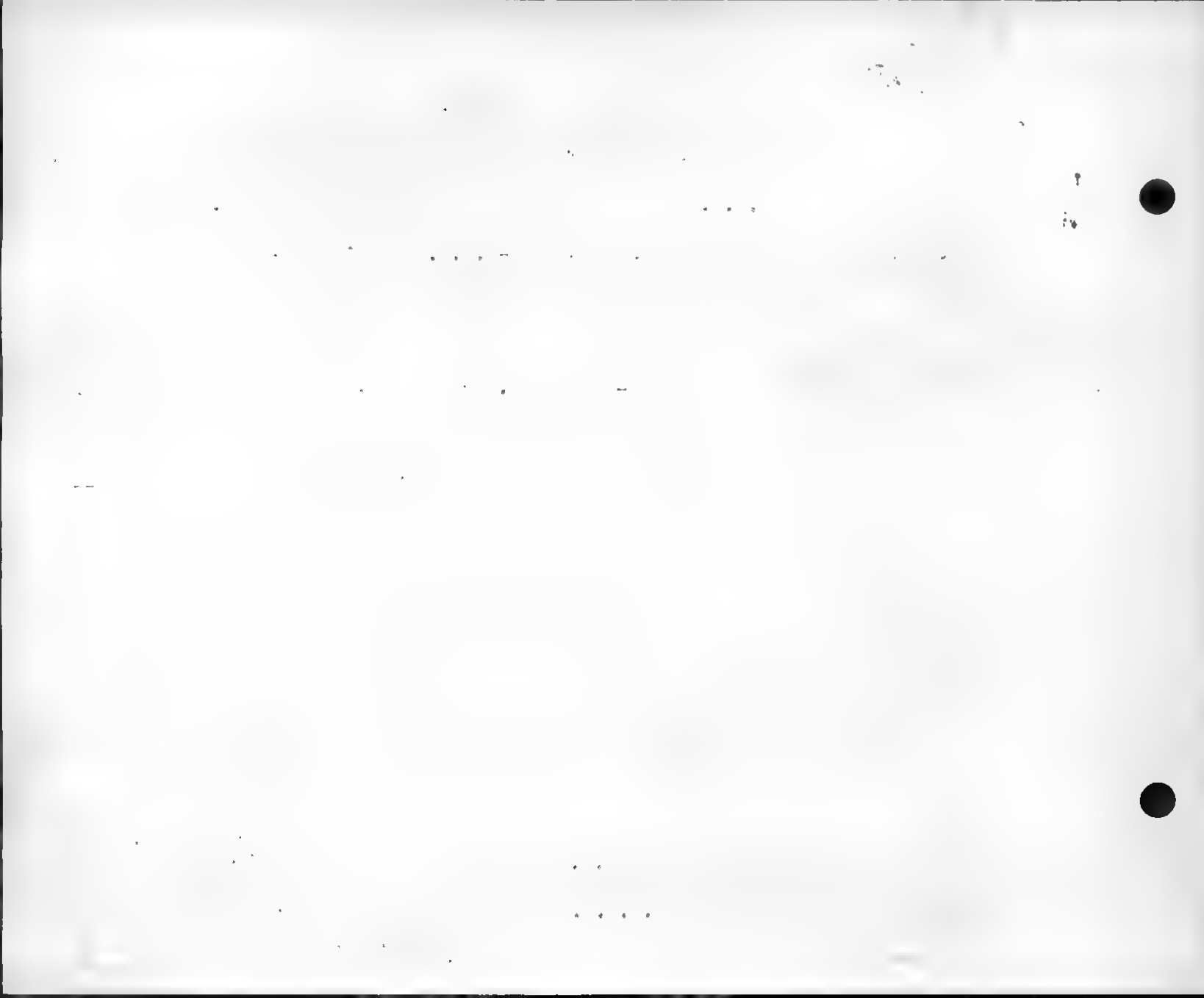


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR		
John		Joseph		Donahoe				ESTIMATED		12	15	1968	6:50 P		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS	9 MONTHS	10 DAYS	11 HOURS	12 MIN	2c. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR
Male	White	October 27-1900	68 YRS							12		15	1968	6:50 P	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH							
Penna		U.S.A.		WIDOWED		DIVORCED		Allegany		Md					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY									
Cumberland		Memorial Hospital-D.O.A.		Retired Farmer											
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
Maryland		Allegany		Flintstone		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
William		Donahoe		Anna		Drenning									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS		RFD #2		Flintstone, Md					
Yes		WW II		218-16-2804		Mrs. Vera Turner									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												Sudden			
4109 CORONARY OCCLUSION															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
(b) CORONARY SCLEROSIS															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
CAUSE OF DEATH		HOUR A.M. P.M. 19													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		Benedict Skitarelic		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED					
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		December 15, 1968							
						ADDRESS (Street, city, town, or county)		CUMBERLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)					
Burial		12/19/68		I.O.O.F. Cemetery		Flintstone		Allegany		Maryland					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Silcox-Merritt Funeral Service		Cumberland, Md		DEC 18 1968		f Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>May</b>		First <b>I.</b>		Middle <b>Dugan</b>		Last		2a. DATE OF DEATH <b>at 6:20 P.M.</b>		2b. HOUR <b>P. M.</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>5/29/1880</b>		6. AGE (In years last birthday) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Allegheny County</b>				Md.	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Allegheny County Infirmary</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>Maryland</b>		ved, if institution. Residence before 13b. COUNTY <b>Allegheny</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INS. DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>510 Pearre Avenue</b>			
14. FATHER'S NAME First <b>George</b>		Middle <b>Keedy</b>		Last		15. MOTHER'S MAIDEN NAME First <b>Alice</b>		Middle <b>Jorden</b>		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>214-01-3632D</b>		17 INFORMANT <b>P.O. Box 599, Cumberland, Md.</b>		Address <b>Allegheny County Infirmary records.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b> <b>410</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Atherosclerosis with Hypertension</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic Cholelithiasis with Cholecystitis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 yrs.</b> <b>many years</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>July 18, 1968</b> , to <b>Dec. 23, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John A. Tepper</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-24-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>John A. Tepper</b>		22e. ADDRESS <b>Memorial Hospital, Cumberland, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 26, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FRG. MEMORIAL PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>					
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, FROSTBURG, MD.</b>		ADDRESS <b>21532</b>		25a. REC'D BY REGISTRAR <b>DEC 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

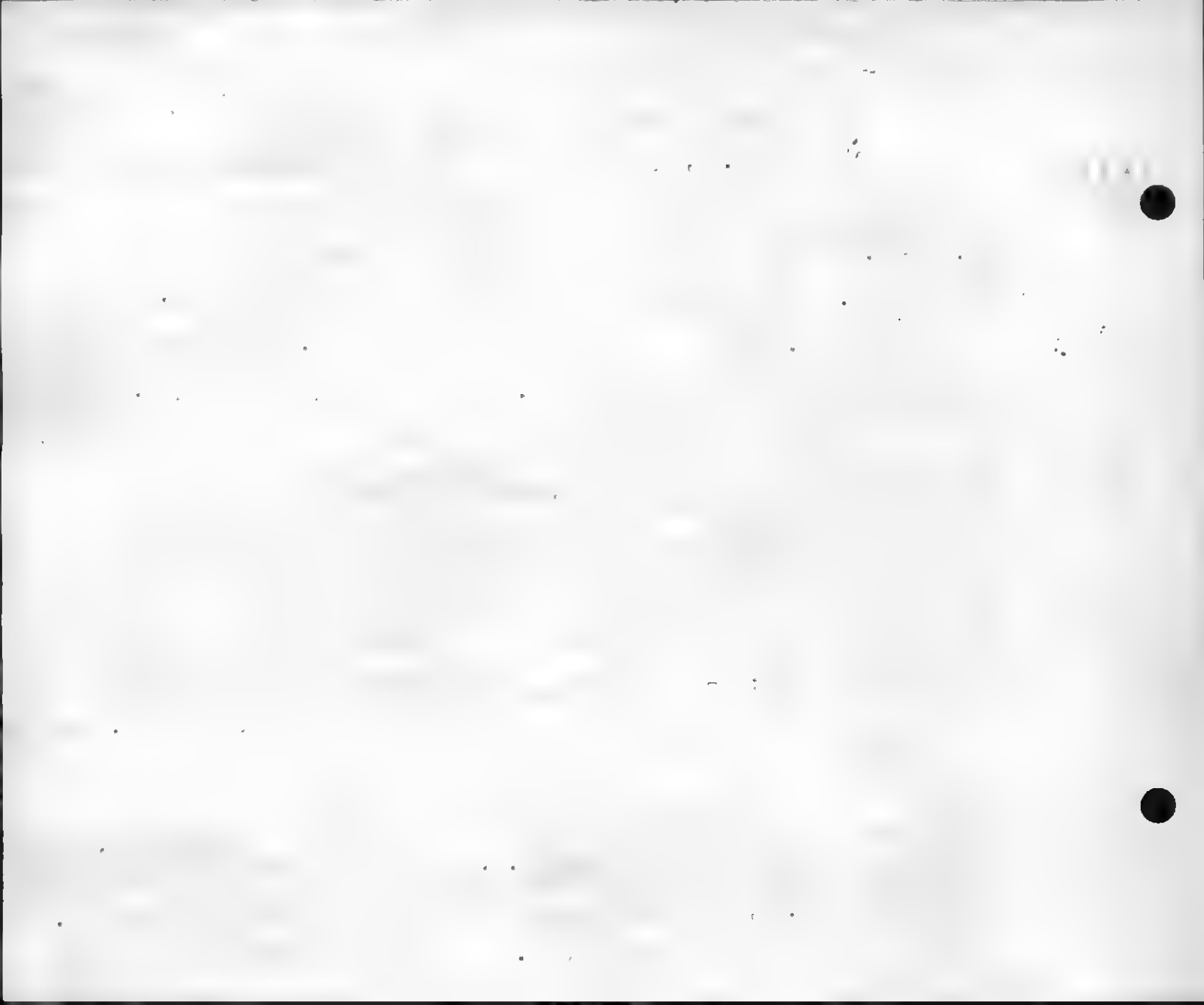


**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with Item 19. Page 5 may be retained for your files.

**TO DEPUTY MEDICAL EXAMINER:**

38

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

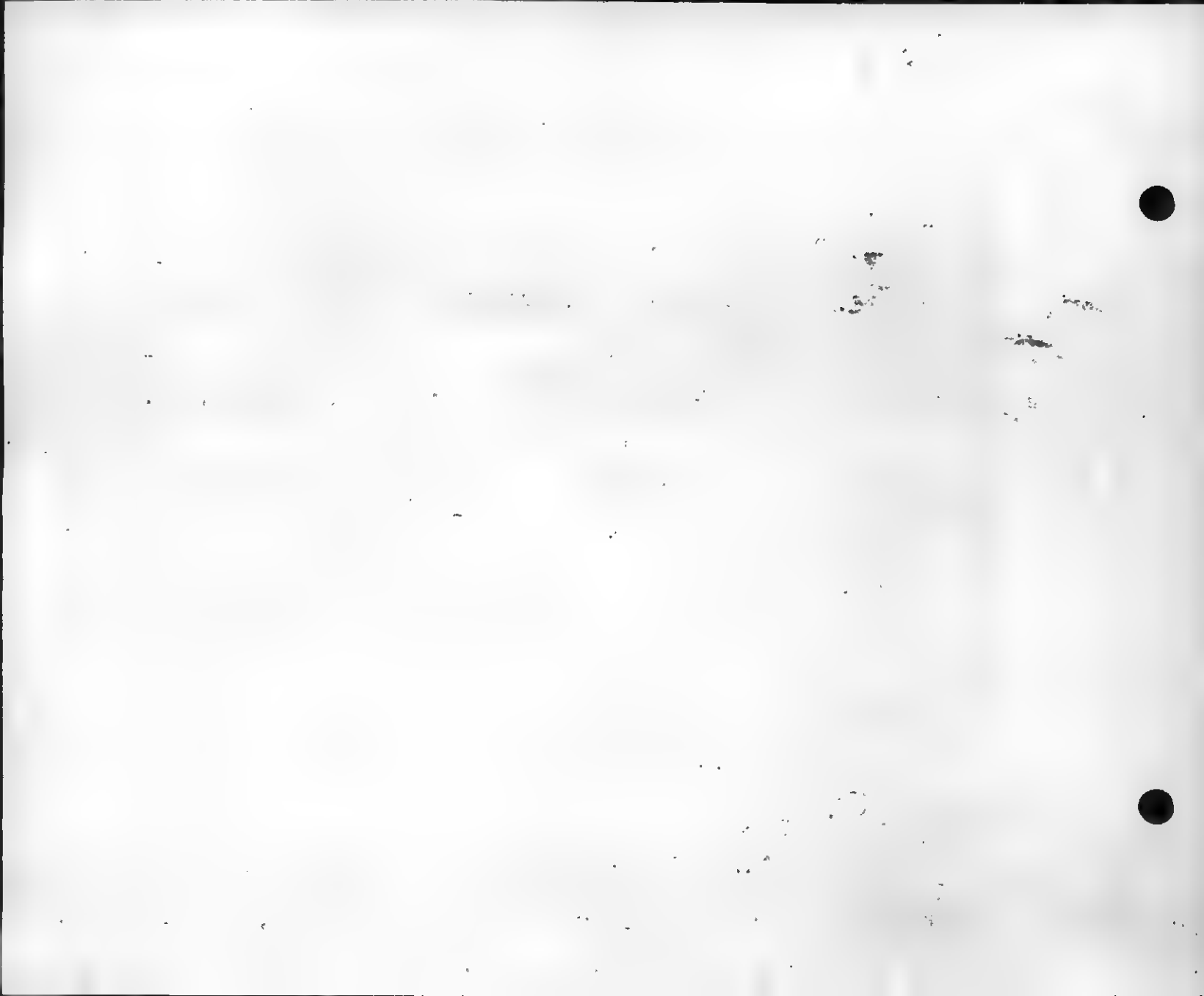
16714

16727

1 DECEASED NAME (Type or print) <b>Ruth Mae Durst</b>			2a DATE OF DEATH Month <b>December</b> Day <b>12</b> Year <b>1968</b>			2b HOUR M	
3 SEX <b>F</b>		4 RACE <b>W</b>		5. DATE OF BIRTH <b>Feb. 8, 1900</b>		6. AGE (In years last birthday) <b>68</b> YRS	
7a BIRTHPLACE (State or foreign country) <b>Pa.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md	
10 CITY OR TOWN OF DEATH <b>Frostburg</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Miner's Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>			13b COUNTY <b>Allegany</b>			13c INSIDE CITY, TOWN OR VILLAGE <b>Midland</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last <b>Edward Durst</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Charlotte Cramer</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-54-8334</b>		17. INFORMANT Address <b>Sherman Durst, Midland, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>							
4409 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Intractable Congestive failure</b> 10 wks							
DUE TO OR AS A CONSEQUENCE OF (c) <b>Generalized Atherosclerosis</b> years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Uremia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from <b>1963</b> , to <b>Dec 12, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 11, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>L.R. Miles, Jr. M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>12-12-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR. M.D.</b>				22e. ADDRESS <b>LONACONING, MD 21539</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/14/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springs Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Springs, Somerset, Pa.</b>	
24. FUNERAL DIRECTOR <b>Kath Newman</b> Grantsville, Md.				25a. REC'D BY REGISTRAR <b>DEC 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



7 1

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 of 7 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

16728

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westernport</u> c. LENGTH OF STAY IN 1b <u>7 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>404 Walnut St.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westernport</u> d. STREET ADDRESS <u>404 Walnut St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Donald W. Fairall</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1968</u>		5. SEX <u>Male</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 27, 1915</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>20 years Army</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		9. AGE (In years) <u>53</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (County, state, or country) <u>Westernport, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Walter Fairall</u>	
14. MOTHER'S MAIDEN NAME <u>Katharyn O'Hanley</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>1942 - 1962</u>		16. SOCIAL SECURITY NO. <u>217-05-0351</u>	
17. INFORMANT <u>Mary Margaret Kolberg</u>		Address <u>79 W. Hampshire</u>		City <u>Piedmont, W.Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Spontaneous Hemorrhage</u> DUE TO (b) <u>Hypoparathyroidism</u> DUE TO (c) <u>Arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>3 months</u> <u>4 years +</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>9</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>Dec. 11, 1968</u> that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>Dec. 9, 1968</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above.					
22a. SIGNATURE <u>Robert W. Bess Jr.</u>		22b. DATE <u>Dec. 11, 1968</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert W. Bess Jr.</u>	
22d. ADDRESS <u>122 Ashfield St., Piedmont, W.Va.</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <u>122 Ashfield St., Piedmont, W.Va.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-16-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>	
23d. LOCATION (City, town or county) <u>Arlington, Va.</u>		23e. ADDRESS <u>W. Harold Fredlock, Jr. Piedmont, W.Va.</u>		23f. REC'D BY REGISTRAR <u>DEC 16 1968</u>	
23g. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		23h. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

12-16-68

Arlington Nat.

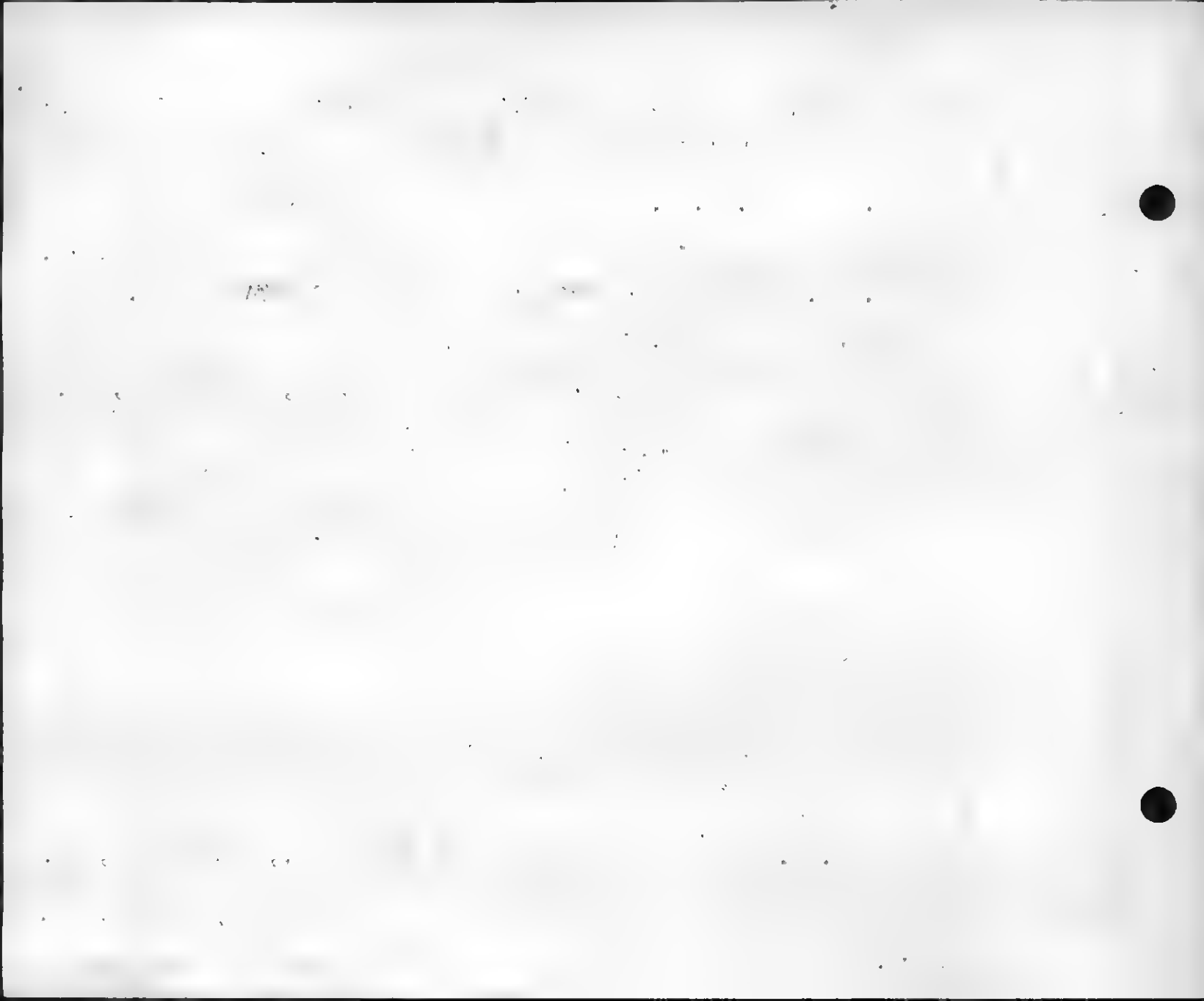
Arlington,

Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>16718</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>16729</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>															
1. DECEASED-NAME (Type or print) <b>WILLIAM</b>				First <b>FOSTER</b>				Last				2a. DATE OF DEATH <b>DEC</b> Month <b>15</b> Day <b>1968</b>		2b. <b>AM.</b> <b>12:35</b>	
3 SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>7/27/1880</b>				6. AGE (In years last birthday) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>			
7a. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>									
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and number) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Steel Co.</b>							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>W. VA.</b>		13b. COUNTY <b>MINERAL</b>		13c. CITY OR TOWN <b>RIDGELEY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>15 WABASH ST.</b>							
14. FATHER'S NAME First <b>PATRICK</b> Middle <b>FOSTER</b> Last				15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>KRESS</b> Last											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>162-18-5379</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Nephritis</b> DUE TO, OR AS A CONSEQUENCE OF <b>arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertension</b> DUE TO, OR AS A CONSEQUENCE OF <b>arteriosclerosis</b> (c) <b>arteriosclerosis</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <b>January 1964</b> to <b>March 1968</b> that (I) (we) last saw the deceased alive on <b>March 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <b>B. Schindler</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED <b>12/16/68</b>							
22d. PHYSICIAN'S NAME (Type) <b>DR. B. SCHINDLER</b>				22e. ADDRESS <b>43 GREENE ST., CUMBERLAND, MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>12/17/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>				23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany Md.</b>							
24. FUNERAL DIRECTOR <b>H. Wayne George Cumberland, Maryland</b>				ADDRESS				25a. REC'D BY REGISTRAR DATE <b>DEC 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

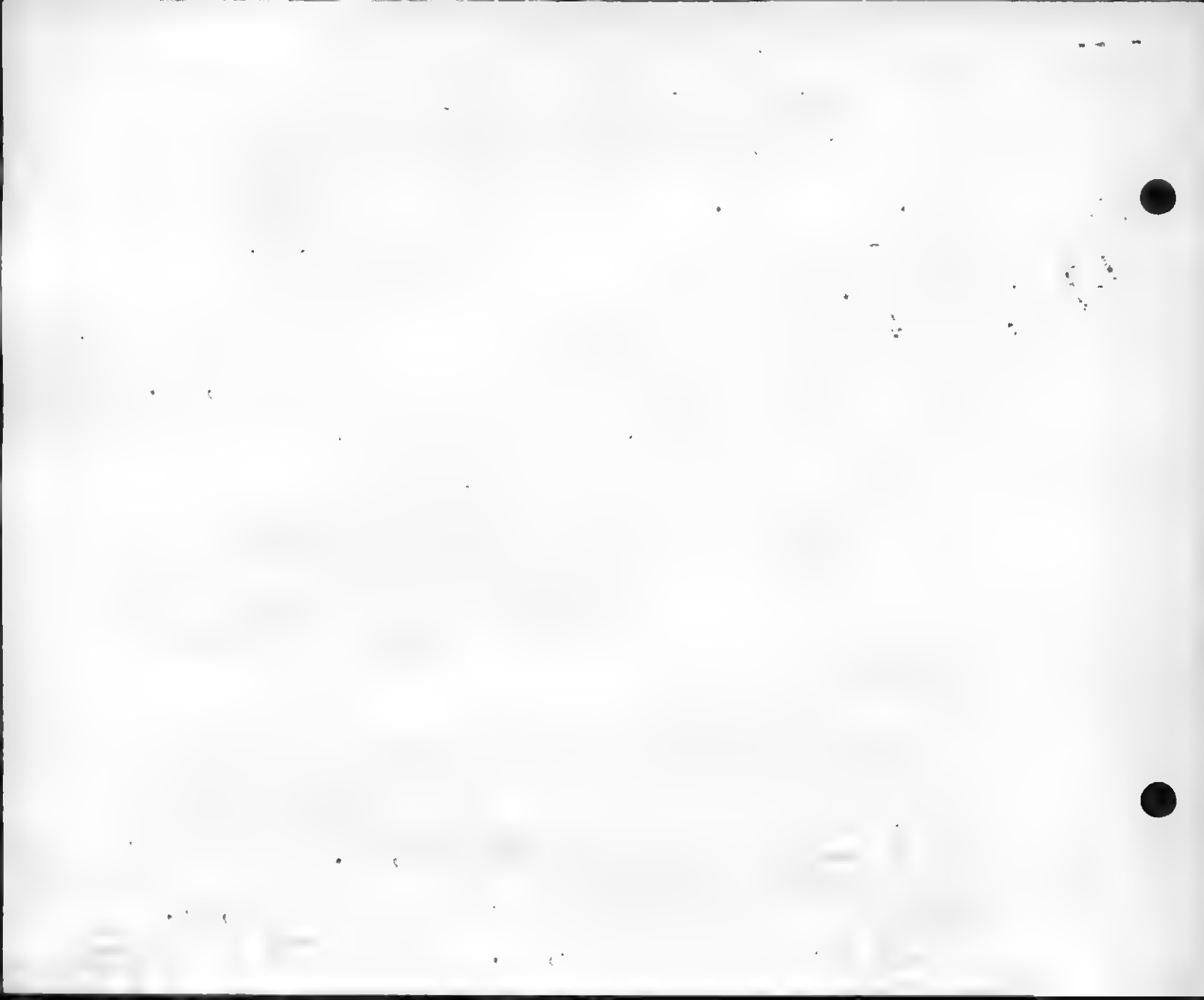
TO FUNERAL DIRECTOR: Page 3 should be mailed as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13717

16730

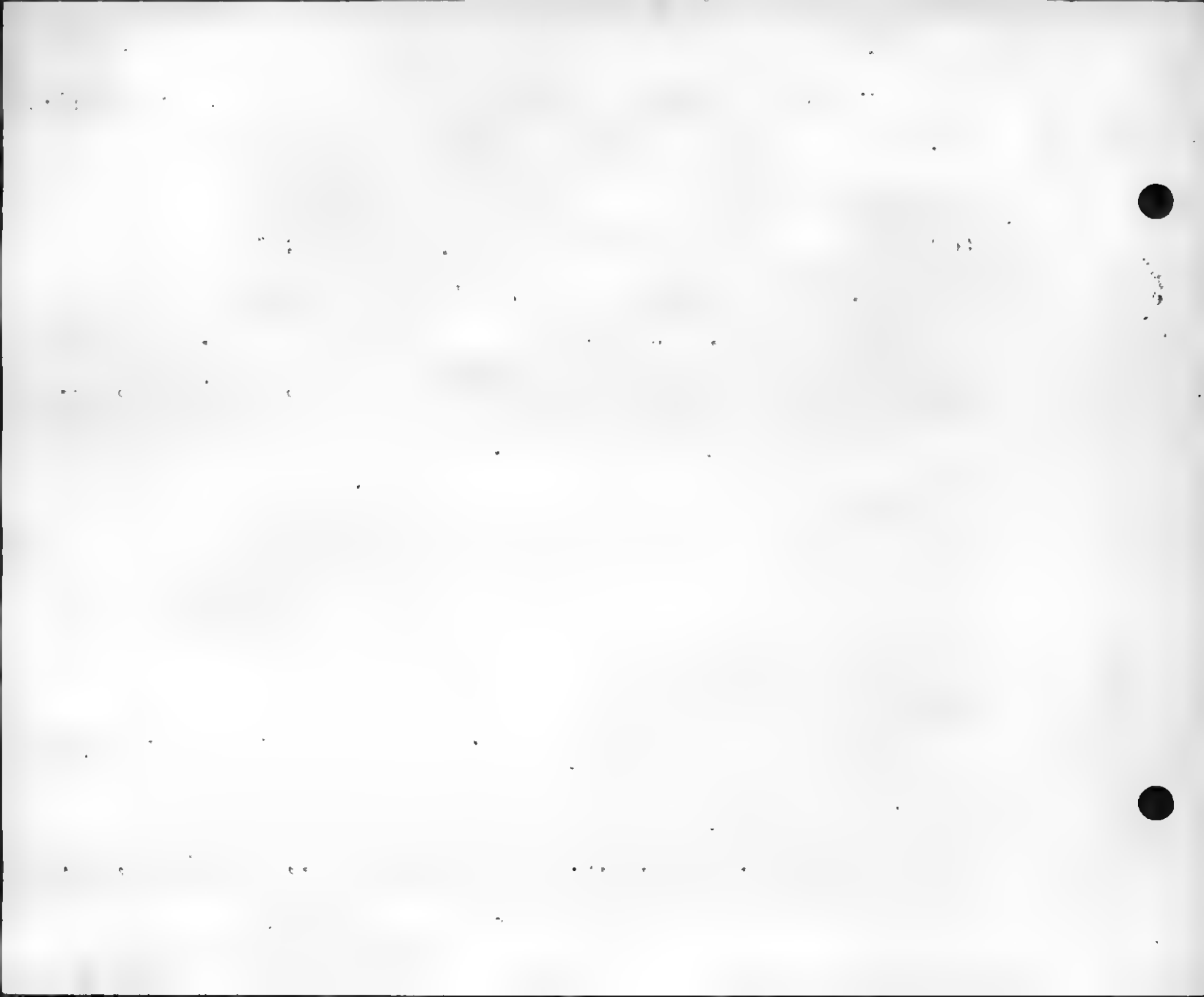
1 DECEASED NAME (Type or Print) First Middle Last <b>Bessie Victoria Foutz</b>			2a DATE KNOWN OF DEATH ESTIMATED Month Day Year <b>12/19/68</b>			2b HOUR M <b>M</b>						
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>2/18/1906</b>		6 AGE (In years or birthday) <b>62</b> YRS MONTHS DAYS		7c. DATE PRONOUNCED DEAD Month Day Year <b>12/19/1968</b>				
7a BIRTHPLACE (State or foreign country) <b>MD.</b>			7b CIT. ZEN OF WHAT COUNTRY? <b>USA.</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Allegany</b> Md			
10. CITY OR TOWN OF DEATH <b>Gilmore-Rural</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD.</b>				13b COUNTY <b>Allegany</b>		13c CITY OR TOWN <b>Gilmore</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
14 FATHER'S NAME First Middle Last <b>William Van Buskirk</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Laura Clise</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b SOCIAL SECURITY NO (If yes give war or dates of service) <b>None</b>		17 INFORMANT ADDRESS <b>William Foutz, Gilmore, Md.</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma Tosis Generalized</b> <b>174X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of right breast</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>174X</b>												
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or RFD No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> MD						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <b>Benedict Skitarelic</b>						22b DATE SIGNED <b>12/19/1968</b>						
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>						23b DATE <b>12/23/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>				
24. FUNERAL DIRECTOR ADDRESS <b>George Eichhorn Lonaconing, Md.</b>						23d LOCATION (City or Town) (County) (State) <b>Moscow, Md.</b>						
25a REC'D BY REGISTRAR <b>DEC 24 1968</b>						25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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16718		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				16731	
Item 1 Film 407 12/18/68 kk				CERTIFICATE OF DEATH			
1 DECEASED-NAME (Type or print) <b>MARGARET ANNA</b>			First Middle Last <b>GOERG Georg</b>		2a. DATE OF DEATH 12 Month 5 Day 68 Year		2b. HOUR 12:45
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>9/30/13</b>		6 AGE (In years lost birthday) <b>55</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>	
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSP.</b>		12a. USUAL OCCUPATION (Kind of work done during most of year or if retired) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>GARRETT</b>		13c. CITY OR TOWN <b>ACCIDENT</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>ADAM J. RICHTER</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>HELEN M. SAUERWALK</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis -</b> <b>15.30</b> DUE TO, OR AS A CONSEQUENCE OF - (b) <b>primary in ovary -</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <b>1967</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer of ovary</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , 19 <b>12/4</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/4</b> , 19 <b>68</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Thomas F. Lewis M.D.</b>				22c. DATE SIGNED <b>12/6/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>THOMAS F. LEWIS, M.D.</b>				22e. ADDRESS <b>500 GREEN ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12/7/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Luth. Church Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Accident, Garrett, Md.</b>	
23e. FUNERAL DIRECTOR <b>Kurt Neumann</b>				23f. ADDRESS <b>Grantsville, Md.</b>		23g. REC'D BY REGISTRAR <b>DEC 13 1968</b>	
				23h. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



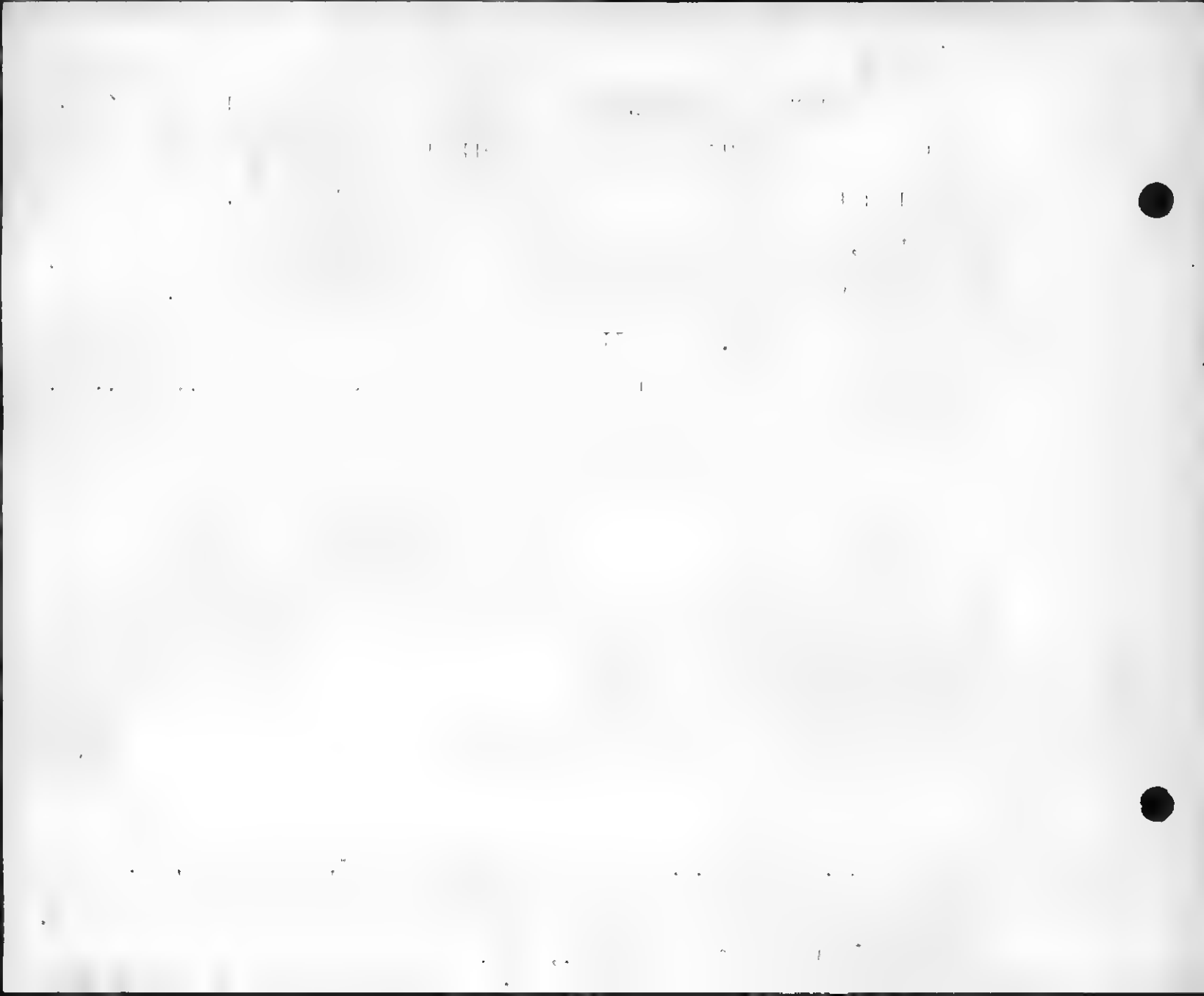
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VR A15  
45M 1/69

MIDDLE																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
16732																	
1 DECEASED NAME (Type or print)			First RUBY			Middle PAULINE			Last GRAHAM			2a DATE OF DEATH Month 12 Day 25 Year 68			2b HOUR 7:18AM		
3 SEX FEMALE			4 RACE WHITE			5 DATE OF BIRTH 7-11-81			6 AGE (In years last birthday) 87 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) WEST VIRGINIA			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH ALLEGANY CO.								
10 CITY OR TOWN OF DEATH CUMBERLAND,			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) S. G. WEISMAN HEART HOSPITAL			12a USAL OCCUPATION (Kind of work done during most of work life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY Own home,								
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MARYLAND			13b COUNTY ALLEGANY			13c CITY OR TOWN CUMBERLAND			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 842 GREENE ST.					
14 FATHER'S NAME First AMOS			Middle S.			Last ARNETT			15 MOTHER'S MAIDEN NAME First HARRIET			Middle CONWAY			Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b SOCIAL SECURITY NO. 214-10-5342			17 INFORMANT HOSPITAL RECORD, 900 SETON DR., CUMB., MD.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Infarction - cerebral thrombosis</u>												3 days					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular disease</u>												10 y					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>and Cerebral arteriosclerosis</u>																	
PART II OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)) <u>Hiatus Hernia</u> <u>Arteriosclerotic Heart Disease</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or RFD No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>67</u> , to <u>25 Dec</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																	
22b SIGNATURE <u>S. G. Weisman</u>			DEGREE M.D.			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 12/25/68								
22d PHYSICIAN'S NAME (Type) S. G. WEISMAN M.D.			22e ADDRESS 59 GREENE ST., CUMBERLAND, MD.														
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 12/28/68			23c NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park,			23d LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.								
24 FUNERAL DIRECTOR H. Wayne George			ADDRESS GEORGES FUNERAL HOME, 202 GREENE ST., CUMB. MD.			25a REC'D BY REGISTRAR DATE DEC 31 1968			25b REGISTRAR'S SIGNATURE Charles Judge								

MEDICAL CERTIFICATE



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<div style="display: flex; justify-content: space-between;"> <div> 16730  Item#13eFilm#G408 12/31/68 vmp </div> <div> <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</b> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div> </div> </div>												16733	
1. DECEASED-NAME (Type or print) <b>EARL</b>				First <b>W.</b> Middle <b>GROWDEN</b> Last				2a. DATE OF DEATH <b>DECEMBER 18</b> Month <b>18</b> Day <b>68</b> Year				2b. HOUR <b>M</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>03-04-12</b>				6. AGE (In years last birthday) <b>56</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>PENNA.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md			
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give full address) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>ELEVATOR OPERATOR</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>TIRE IND.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital on date of admission) STATE <b>MD.</b>				13b. COUNTY <b>ALLEGANY</b>				13c. CITY OR TOWN <b>CUMBERLAND</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. INSIDE CITY LIMITS? <b>RT. 3 BEDFORD ROAD</b>			
14. FATHER'S NAME First <b>ESBY</b> Middle <b>GROWDEN</b> Last				15. MOTHER'S MAIDEN NAME First <b>LILLIE</b> Middle <b>HARDINGER</b> Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>174 16 8382</b>				17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia etiology unknown</b> <b>486X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>1968</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>												<b>25 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Cystitis &amp; Prostatitis Rheumatoid arthritis</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>12</b> Day <b>18</b> Year <b>1968</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/17</b> , 19 <b>68</b> , to <b>12/18</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/17</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>S. G. Weisman</b> DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>S. G. WEISMAN, M.D.</b>												22e. ADDRESS <b>59 GREEN ST. CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>DEC. 21, 1968</b>				23c. NAME OF CEMETERY OR CREMATORY <b>FELLOWSHIP CEMETERY</b>				23d. LOCATION (City or Town) <b>CENTERTVILLE</b> (County) <b></b> (State) <b></b>	
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>				ADDRESS <b>CUMBERLAND, MD</b>				25a. REC'D BY REGISTRAR <b>DEC 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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MD. STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16721

16734

1. DECEASED NAME (Type or print) <b>Carter McNeil Harness</b>			2a. DATE OF DEATH <b>15, 1968</b> Dec. Month <b>15</b> Day <b>1968</b>			2b. HOUR A.M. <b>4:30</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 20, 1906</b>		6. AGE (in years last birthday) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS <b>15</b> DAYS <b>15</b> HOURS <b>30</b> MIN.		
7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.				
10. CITY OR TOWN OF DEATH <b>Cumberland</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>D.O.A. Memorial H.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Truck Driver-Textile</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>W. Va.</b>			13b. COUNTY <b>Mineral</b>		13c. CITY OR TOWN <b>Ridgeley</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>12 Second Ave.</b>	
14. FATHER'S NAME First <b>George</b> Middle <b>S.</b> Last <b>Harness</b>			15. MOTHER'S MAIDEN NAME First <b>Catherine</b> Middle <b>Plauger</b> Last <b>Plauger</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>214-07-1013</b>		17. INFORMANT Address <b>Daughter</b> <b>Miss Patricia Harness, Ridgeley, W. Va.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4127</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4 yrs</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medico examiner)			21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <b>19</b> P.M. _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____				
22a. I certify that (I) (this hospital) attended the deceased from <b>4/3/65</b> , 19____, to <b>12/15/68</b> , that (I) (we) last saw the deceased alive on <b>12/15/68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Dr. Richard J. Williams</b>			22c. DATE SIGNED <b>Dec. 17, 1968</b>			22d. PHYSICIAN'S NAME (Type) <b>Dr. Richard J. Williams</b>				
22e. ADDRESS <b>122 S. Centre St., Cumberland, Md.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Dec. 18, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>		
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>DEC 20 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <p>4 1</p> <p>10720</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p><b>CERTIFICATE OF DEATH</b></p> <p>16735</p> </div>																			
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH			2b HOUR							
Annie			Elizabeth		Hartell		Dec.			Month 8 Day 1968		ear 4: P M							
3 SEX		4 RACE		5 DATE OF BIRTH				6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN							
Female		White		Dec. 26, 1876				91 YRS											
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH										
Maryland			USA						Allegany Md										
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland				121 Springdale St.				housewife				Own Home							
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE				13b COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER									
Md.				Allegany		Cumberland				121 Springdale St.									
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME													
First Middle Last						First Middle Last													
John Snyder						Sarah Shank													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO				17 INFORMANT				Address							
NO								Mr. Frank W. Hartell, Cumberland, Md.-Son											
1B CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>Accumulations</u>												3 min							
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
(b) <u>Carcinoma Cervix</u>												10 min							
DUE TO, OR AS A CONSEQUENCE OF																			
(c) <u>Cardiac Decompensation</u>												3 hrs							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f LOCATION		Street or R.F.D. No		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>68</u> , to <u>Dec 5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE												DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
<u>Clay E. Durrett</u>																Dec. 9, 1968			
22d PHYSICIAN'S NAME (Type)												22e ADDRESS							
Dr. Clay E. Durrett, MD												236 Virginia Ave., Cumberland, Md.							
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)									
Burial				Dec. 11, 1968		Hillcrest Burial Park				Cumberland, Allegany, Md.									
24. FUNERAL DIRECTOR												ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.														DEC 13 1968		<u>Charles Judge</u>			

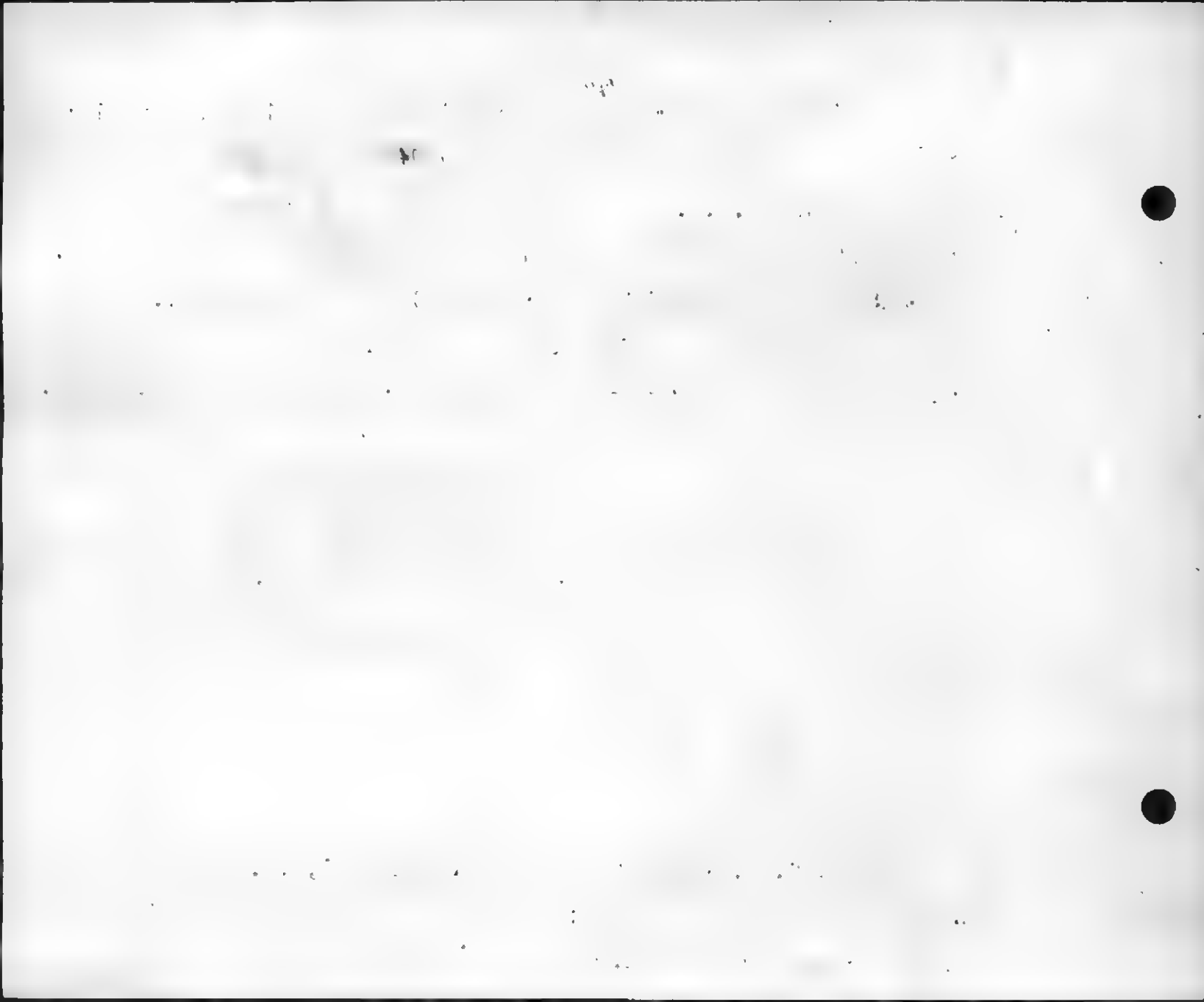


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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16723		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		16736	
CERTIFICATE OF DEATH					
1 DECEASED-NAME (Type or print) First Middle Last <b>THOMAS KINNEY HASTINGS</b>			2a. DATE OF DEATH Month Day Year <b>12 25 68</b>		2b. HOUR <b>11:40AM</b>
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>12-7-64</b>		6 AGE (n years) lost birthday <b>24</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH <b>ALLEGANY</b>		Md			
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during life, even if retired) <b>Salesman</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Mens Clothing</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>	13c. CITY OR TOWN <b>CUMBERLAND</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>149 POLK ST.</b>
14. FATHER'S NAME First Middle Last <b>JAMES HASTINGS</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MOLLIE KELLER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>214-07-1094</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of sigmoid colon with metastases to bladder and retroperitoneal tissues</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <b>1533</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pulmonary TB - cured</b> <b>Arteriosclerotic Cardiovascular Disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/24</b> , 19 <b>68</b> , to <b>12/25</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/24</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dr. S. G. Weisman</b>				22c. DATE SIGNED <b>12/25/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>				22e. ADDRESS <b>CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>		23b. DATE <b>12/28/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Circle Hill Cemetery,</b>	
23d. LOCAT ON (City or Town) (County) (State) <b>Punxsutawney, Jefferson, Penna.</b>					
24 FUNERAL DIRECTOR <b>H. Wayne George 202 Greene St. Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

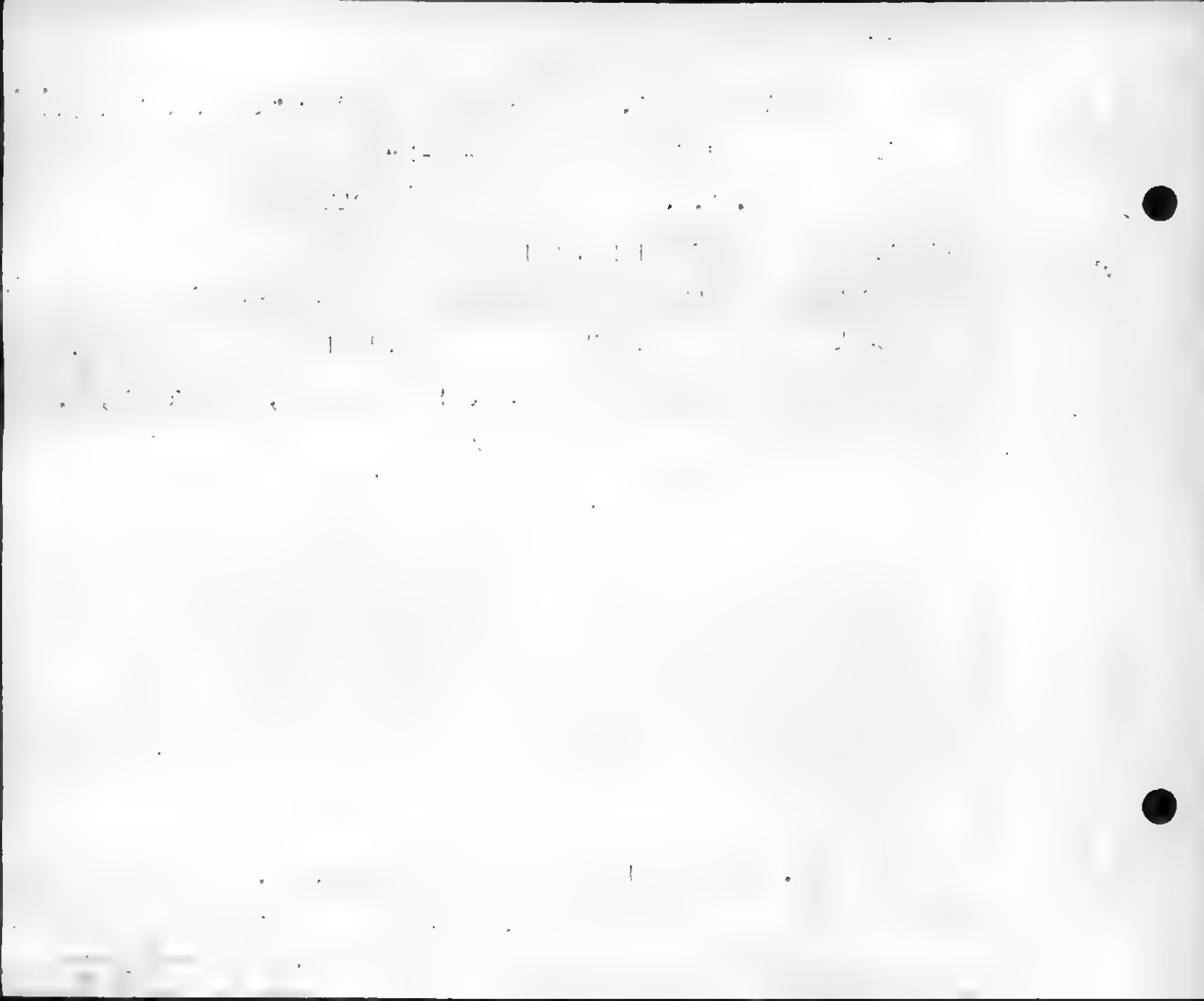
16724

16737

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR	
ALBERT		F.		HENKEL	DECEMBER 13, 1968		5:15 PM	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN.
MALE	WHITE		3-20-1902		66 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
MARYLAND		U. S. A.				ALLEGANY Md.		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		MEMORIAL HOSPITAL		Trucker		Rail Road		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER		
MARYLAND		ALLEGANY		CUMBERLAND		Cumberland, Md. Winchester Rd.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME					
First Middle Last CARL HENKEL			First Middle Last CHRISTINA QUANTZ					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT Address				
NO		214-05-9207		MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial infarction</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from <i>Dec 15, 1968</i> to <i>Dec 13, 1968</i> , that (I) (we) lost saw the deceased alive on <i>Dec 13, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <i>12/16/68</i>		
22d PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER				22e ADDRESS CUMBERLAND, MD.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		12/17/68		Greenmount Cemetery		Cumberland Allegany Md.		
24 FUNERAL DIRECTOR William G. Kight				ADDRESS Cumberland, Md.		25a REC'D BY REGISTRAR DATE DEC 20 1968		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

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16725

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16738

1 DECEASED NAME (Type or Print)		First <b>ALICE</b>		Middle <b>J. MILDRED</b>		Last <b>HERATH</b>		2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day Year		2b HOUR 1:45 PM	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>MAY 23, 1901</b>		6 AGE (in years last birthday) <b>67</b> YRS		7 UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>ALLEGANY</b>		2c DATE PRONOUNCED DEAD Month Day Year <b>DEC 3 1968</b>		2d HOUR 1:45 PM	
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Sacred Heart Hospital-DOA</b>		12a USUAL OCCUPATION (Kind of work done during most of last year) <b>RETIRED EMPLOYEE ROSEWOOD STATE HOSPITAL</b>		12b KIND OF BUSINESS OR OCCUPATION <b>HOSPITAL</b>		13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b COUNTY <b>ALLEGANY</b>	
13c CITY OR TOWN <b>CUMBERLAND</b>		3a INSIDE CITY - APTS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <b>217 GLENN STREET</b>		14 FATHER'S NAME First Middle Last <b>AMOS GROSS</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>VICTORIA BOWMAN</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, if on unknown) <input checked="" type="checkbox"/> NO (If yes give war or dates of service)	
16b SOCIAL SECURITY NO. <b>212-24-1260a</b>		17 INFORMANT <b>WALTER P. DENNISON</b>		ADDRESS <b>400 BEDFORD ST. CUMBERLAND</b>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>--</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4</b>	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State		22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Dec. 3, 1968</b>		ADDRESS (Street, city, town, or county) <b>CUMBERLAND, MARYLAND</b>		23a. REC'D BY REGISTRAR DATE <b>DEC 5 1968</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE <b>6 DEC 68</b>		23c NAME OF CEMETERY OR CREMATORY <b>HILLCREST BURIAL PARK</b>		23d LOCATION (City or Town) (County) (State) <b>RFD#2 CUMBERLAND ALLEGANY MD.</b>		24. FUNERAL DIRECTOR <b>H. LEE SILCOX</b>		ADDRESS <b>404 DECATUR ST CUMBERLAND MD.</b>	
25a. REC'D BY REGISTRAR DATE <b>DEC 5 1968</b>		25b REGISTRAR'S SIGNATURE <i>William J. Jones</i>		25c. REGISTRAR'S SIGNATURE <i>William J. Jones</i>		25d. REGISTRAR'S SIGNATURE <i>William J. Jones</i>		25e. REGISTRAR'S SIGNATURE <i>William J. Jones</i>		25f. REGISTRAR'S SIGNATURE <i>William J. Jones</i>	

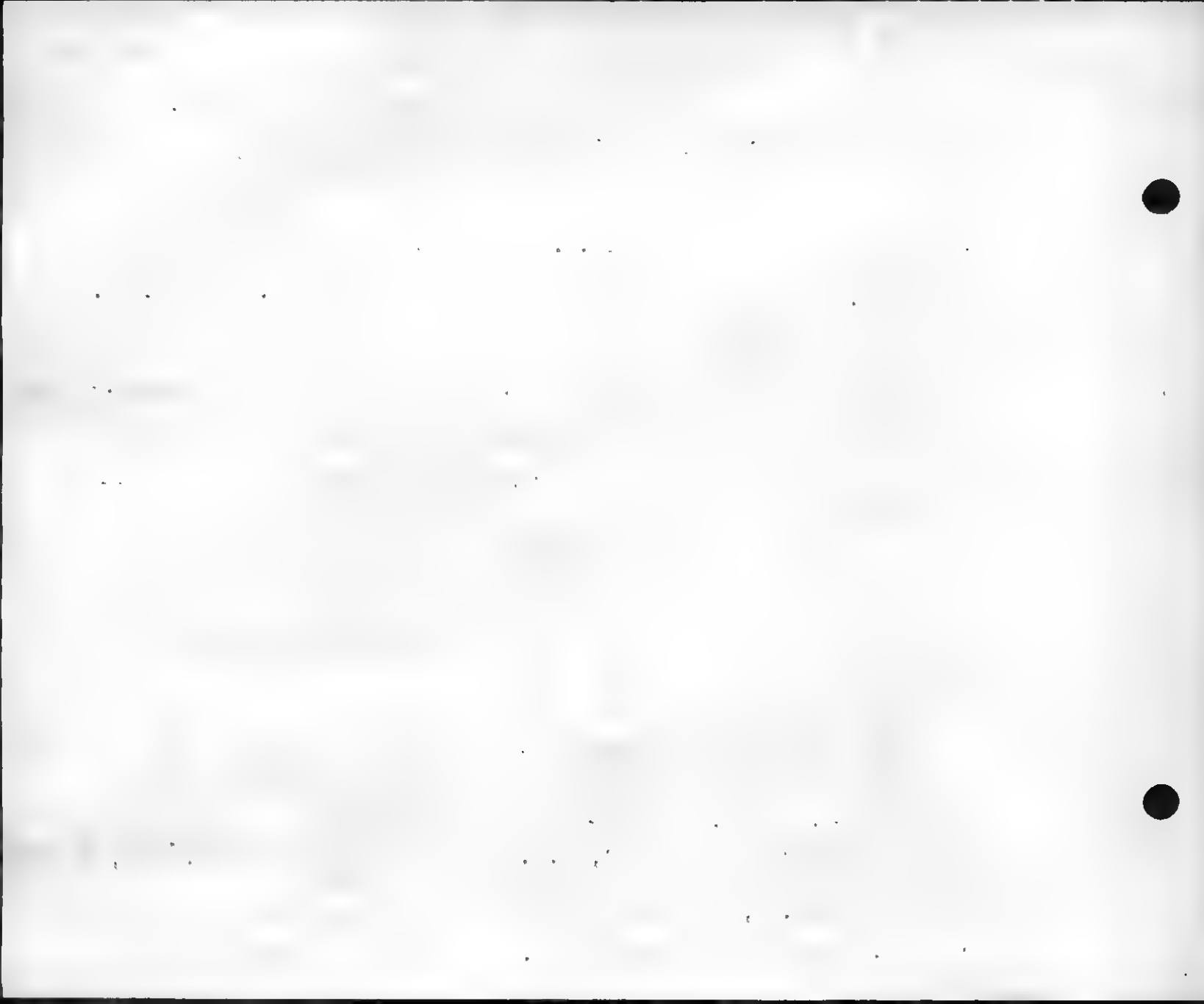


# FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED			Month Day Year 2b HOUR		
Mary Catherine Herboldsheimer						Dec. 28 1968			12:00 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR
Female	White	July 21, 1904	64 YRS					Dec. 28 1968			1:20 PM
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			USA						Allegany Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a JSJA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cumberland			D.O.A. Memorial H.			Retired Fire Builder-Tire					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET AND NUMBER		
Md.			Allegany			Cumberland			135 N. Mechanic St.		
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
John Earsom			Minnie Dowden								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS					
no						Mrs. Leslie Brinkman, Cumberland, Md. - Sister					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CORONARY OCCLUSION SUDDEN											
4109 DUE TO, OR AS A CONSEQUENCE OF											
CORONARY SCLEROSIS											
---											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
CAUSE OF DEATH			HOUR A.M. P.M. 19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town County State		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			BENEDICT SKITARELIC, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			Dec. 28, 1968		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Cumberland, Maryland		
						ADDRESS (Street, city, town, or county)					
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			Dec. 31, 1968			Hillcrest Burial Park			Cumberland, Allegany, Md.		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
James F. Scarpelli, Cumberland, Md.						DATE JAN 3 1969			Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		2b HOUR P	
JOHN		H.		JEFFRIES				12 Month 23 Day 68 Year		3:26 PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (n years last birthday)		7 UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
MALE		WHITE		4/8/17		51 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md	
MARYLAND		USA				ALLEGANY					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during previous 12 months if not retired)		12b KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		SACRED HEART HOSPITAL		ADMINISTRATIVE							
13a USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13b STREET AND NUMBER			
MARYLAND		ALLEGANY		MIDLAND							
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
JOHN		JEFFRIES						ANNE STEVENS JEFFRIES			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO.		17 INFORMANT		Address					
YES		213 01 6083		SACRED HEART HOSPITAL		900 SETON DRIVE CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Subarachnoid Hemorrhage / day</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
3302											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1965 to 12/23, 1968, that (I) (we) last saw the deceased alive on 12/23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.											
22b SIGNATURE		22c. DATE SIGNED		22d PHYSICIAN'S NAME (Type)		22e. ADDRESS					
<u>S. G. Weisman</u>		12/24/68		DR. S. G. WEISMAN		59 GREENE ST -CUMBERLAND, MD.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		12/26/1968		Memorial Park		Frostburg, Md.					
24. FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE							
EICHORN FUNERAL HOME -LONACONING, MD.		DEC 30 1968		<u>Charles Judge</u>							

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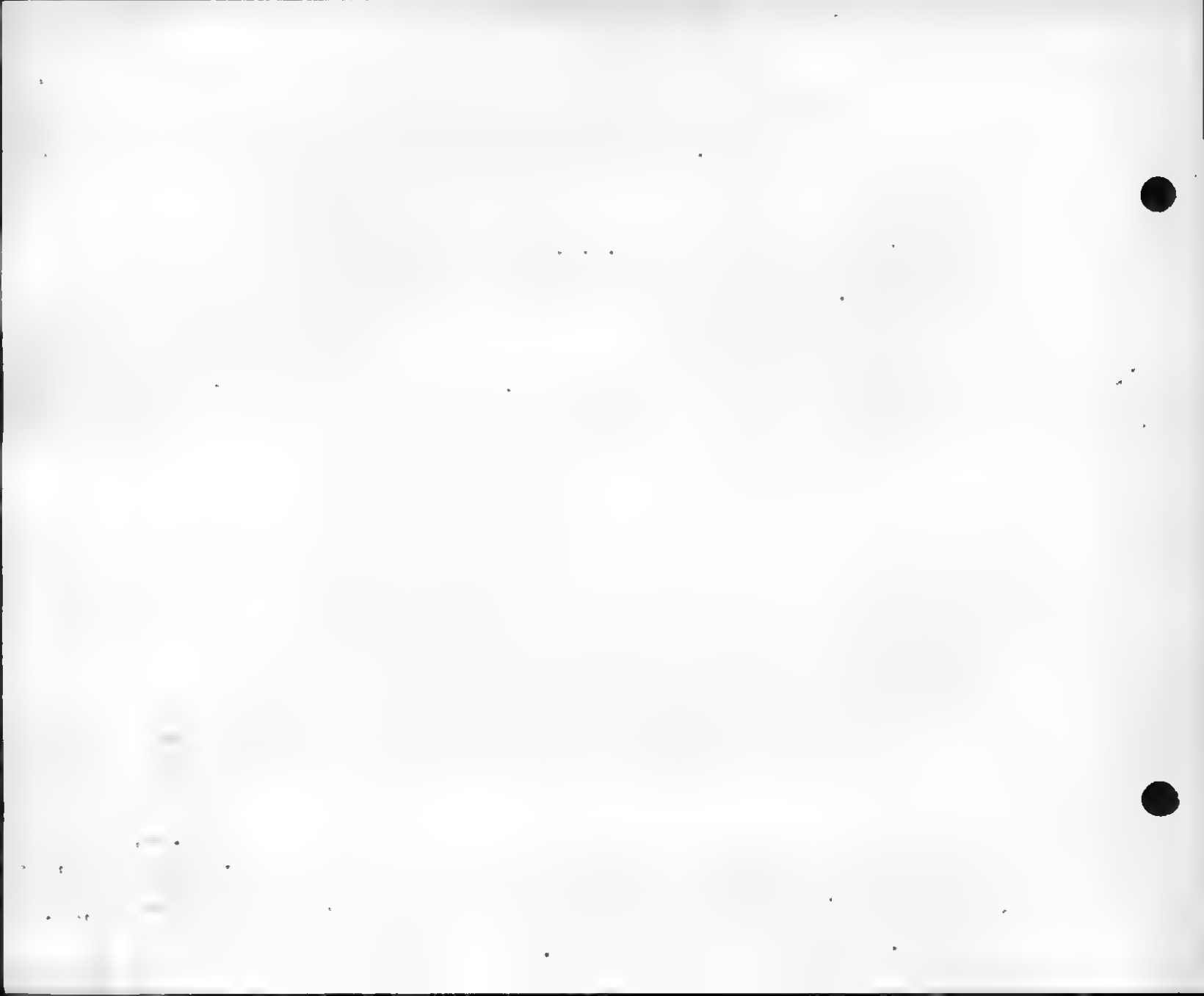
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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First		Middle		Last		
Sophia			A.		Jolley				
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Female	White	July 2, 1899		69 YRS					
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland			USA				Allegany Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Cumberland			D.O.A. Memorial			Housewife			Own Home
13a USUA. RESIDENCE (Where deceased lived, if institution Residence before admssion) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Md.			Allegany		Cumberland				Mexico Farms
14 FATHER'S NAME				First		Middle		Last	
Frederick Bierman									
15 MOTHER'S MAIDEN NAME				First		Middle		Last	
Minnie Schultz									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no						Mr. Harold Jolley, Mexico Farms-Son			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>201</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden --
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
2. a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No			City or Town		County
21f. LOCATION Street or R.F.D. No			City or Town			County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, MD					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					22b. DATE SIGNED <u>Dec. 10, 1968</u>				
					ADDRESS (Street, city, town, or county) <u>Rt. 9, Cumberland, Md.</u>				
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Burial			12-13-1968		Davis Memorial Cemetery			Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR					ADDRESS				
James F. Scarpelli, Cumberland, Md.									
25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
DA DEC 13 1968					J Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First ALFRED			Middle CONRAD			Last KELLER			2a. DATE OF DEATH December Day 4, Year 1968			2b. HOUR 4:25AM		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH FEBRUARY 14, 1912			6. AGE (In years) 56-58 YRS.			7. UNDER YEAR MONTHS DAYS			8. UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.								
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY BODY & FENDER SHOP								
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER MC GEES TRAILOR CT. CREEK R.					
14. FATHER'S NAME First WILLIAM			Middle C.			Last KELLER			15. MOTHER'S MAIDEN NAME First MARGARET			Middle DORSEY			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO. 220-10-2623			17. INFORMANT HOSPITAL RECORD- 900 SETON DRIVE, CUMB., MD						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rupture of Terminal aortic</i> 4419 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Disseminated</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 451X																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (1) (this hospital) attended the deceased from 12-13-68, 1968, to 12-14-1968, that (1) (we) last saw the deceased alive on 12-13-1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Earl R. Paul</i>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (Type) EARL R. PAUL, M.D.			22e. ADDRESS 414 N. MECHANIC ST., CUMBERLAND, MD.														
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Dec. 16, 1968			23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.								
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME- CUMBERLAND, MD.			ADDRESS			25a. REC'D BY REGISTRAR DEC 20 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								

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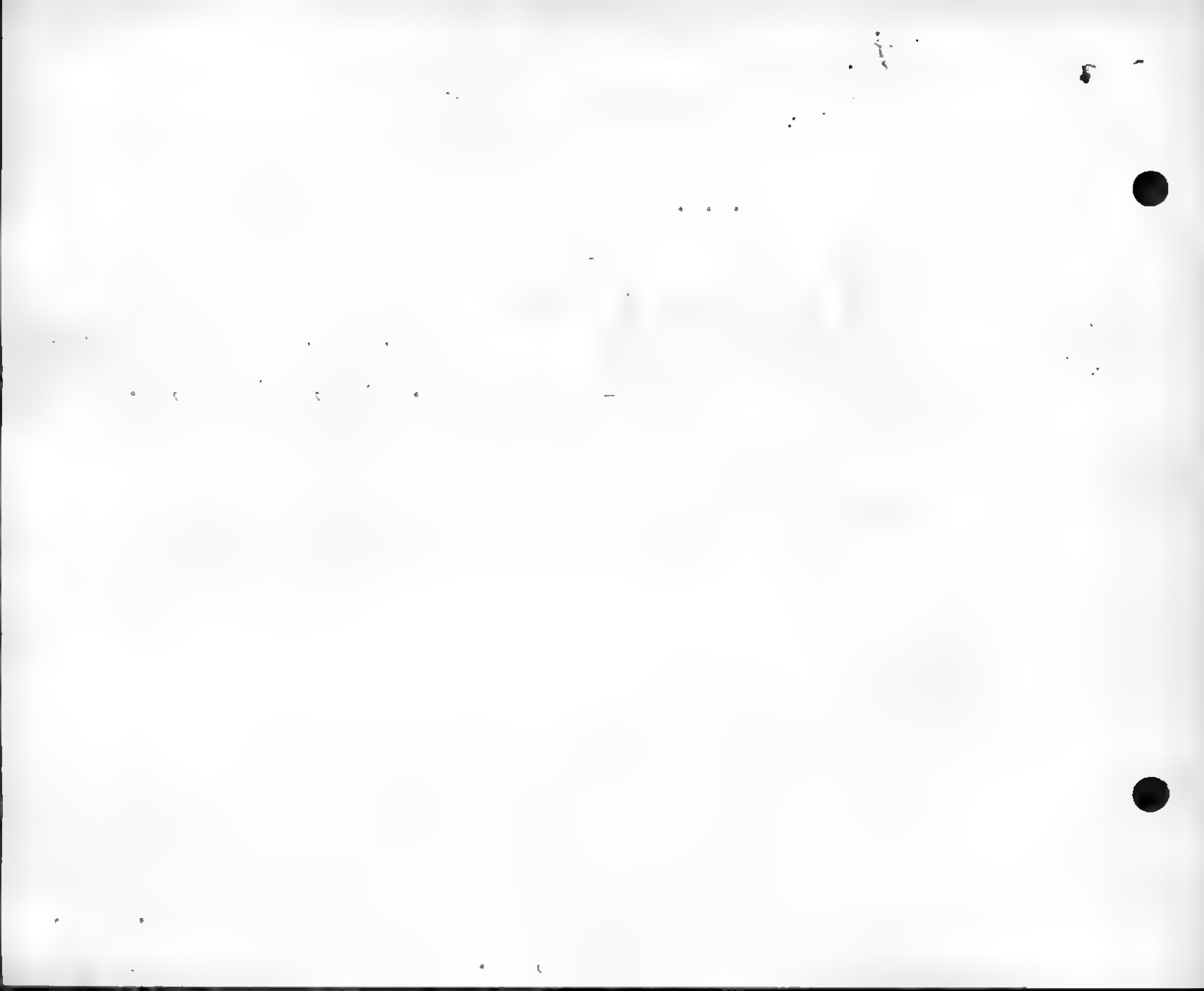
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16730					16743				
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
John Edward Kroll						Month Day Year			M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. YRS
Male		White		7/7/1897			71		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Md		U.S.A.					Allegheny Md		
1D. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Frostburg			Migders Hospital			Retired Baker			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Md			Allegheny			Midland			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
John Kroll			Constance Retallick						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
no			213-01-6082A			John E. Kroll, Midland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Ischemia</u>									
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic coronary insufficiency</u>									1 year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Generalized Atherosclerosis</u>									years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Chronic Gastritis &amp; enteritis</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar</u> , 19 <u>68</u> , to <u>Dec 12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 19</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death									
22b. SIGNATURE <u>H.R. Miles, Jr. M.D.</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED <u>12-21-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>H.R. MILES, JR., M.D.</u>						22e. ADDRESS <u>LONA CONING MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			12/23/68			Memorial Park			Frostburg A. Md.
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George Eichhorn						Lonaconing, Md.		DEC 24 1968 <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
ANNIE			LEITH			12 PM 68		9:15 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birth day)		IF UNDER 1 YEAR		
FEMALE		WHITE		9-6-16		32 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
MARYLAND		U.S.A.				ALLEGANY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL HOSPITAL			Cashier		Ins. Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		CUMBERLAND				207 GRAND AVENUE	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
JAMES STEVENSON			MARY A FAIRGRIEVE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
			220-10-0609		MEMORIAL HOSPITAL		CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Carcinoma testes - 2° Ca breast</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
1968 Ca D Breast										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 22</u> , 19 <u>68</u> , to <u>11 Dec</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11 Dec</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE										
22c. DATE SIGNED										
22d. PHYSICIAN'S NAME (Type)										
22e. ADDRESS										
DR. F. MILTENBERGER CUMBERLAND, MD.										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			12/14/68		Zion Memorial Burial Park		Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
H. Wayne George			Cumberland, Md.			DEC 16 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16738

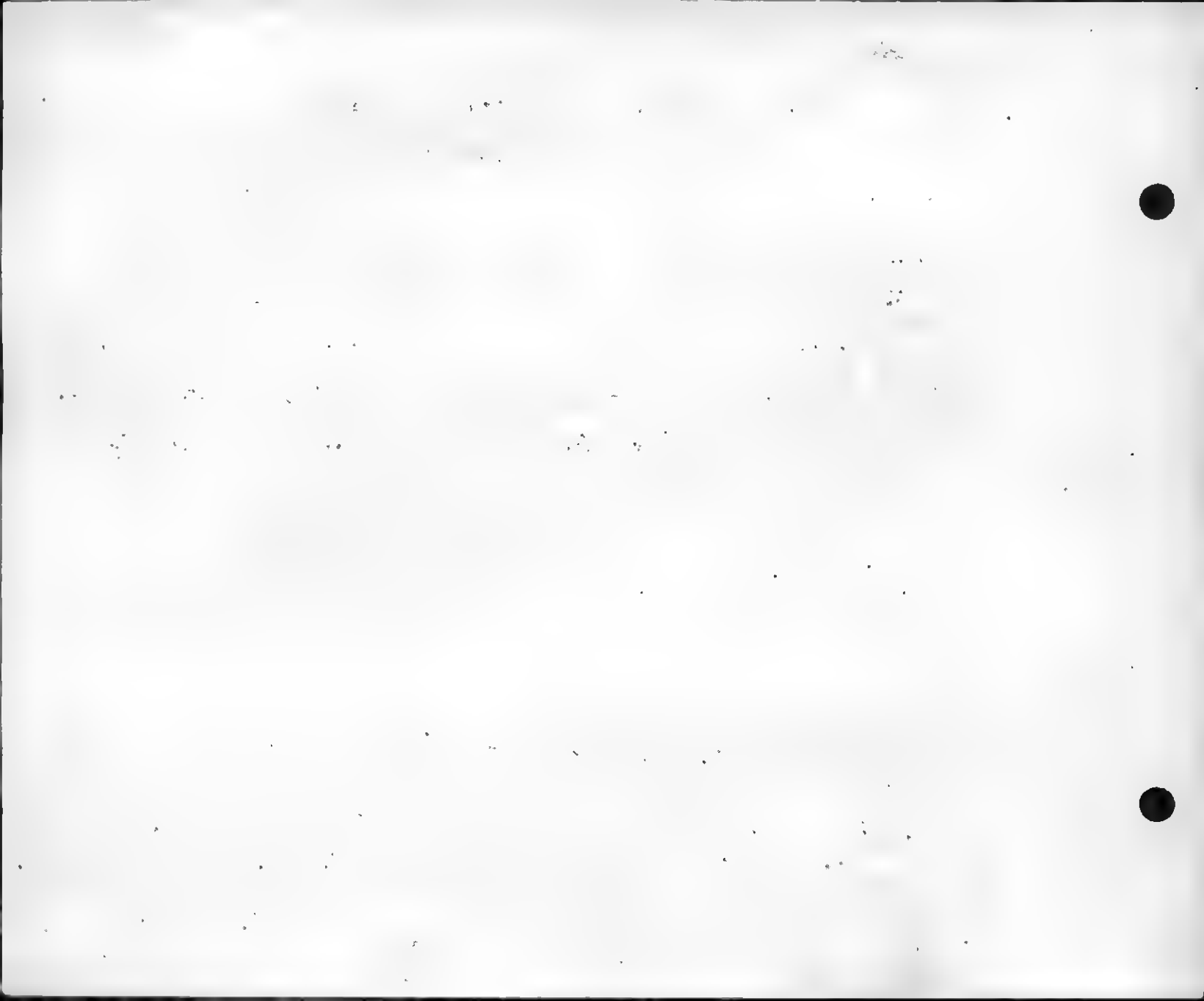
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16745

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
JOHN		W.		LEWIS	DECEMBER 22 1968		3:30 PM		
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE	WHITE		10/2/1898		70 YRS.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
MARYLAND	USA				ALLEGANY				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CHAMBERLAND		MEMORIAL HOSPITAL		RETIRED					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		ECKHART				---	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
ABRAHAM LEWIS			MARTHA WILLISON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT Address					
NO		220-10-2273		MEMORIAL HOSPITAL, CHAMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic Adenocarcinoma Colon</i>								Days	
DUE TO, OR AS A CONSEQUENCE OF (b)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<i>Intense but controlled hemorrhage</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 28, 1968</i> to <i>Dec 22, 1968</i> , that (I) (we) last saw the deceased alive on <i>Dec 22, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<i>[Signature]</i>		<i>12/21/68</i>							
22d. PHYSICIAN'S NAME (Type)		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
DR. HIMMELWRIGHT									
22e. ADDRESS		133 VIRGINIA AVE., CHAMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		12/24/68		ECKHART CEMETERY		ECKHART, ALLEGANY, MD.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
M. J. JONES		JAN 9 1969		<i>[Signature]</i>					

30 JAN 17 1969

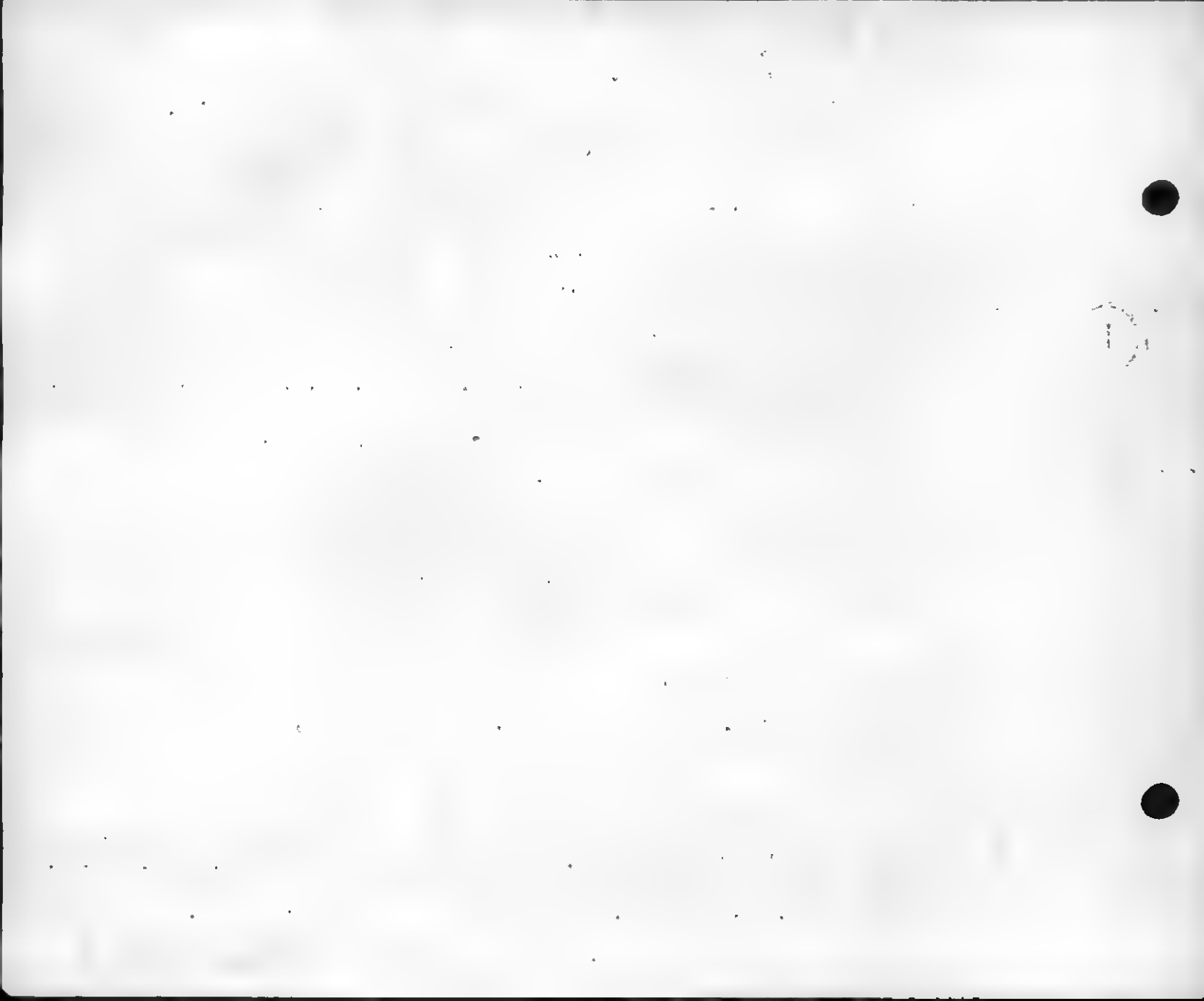


**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

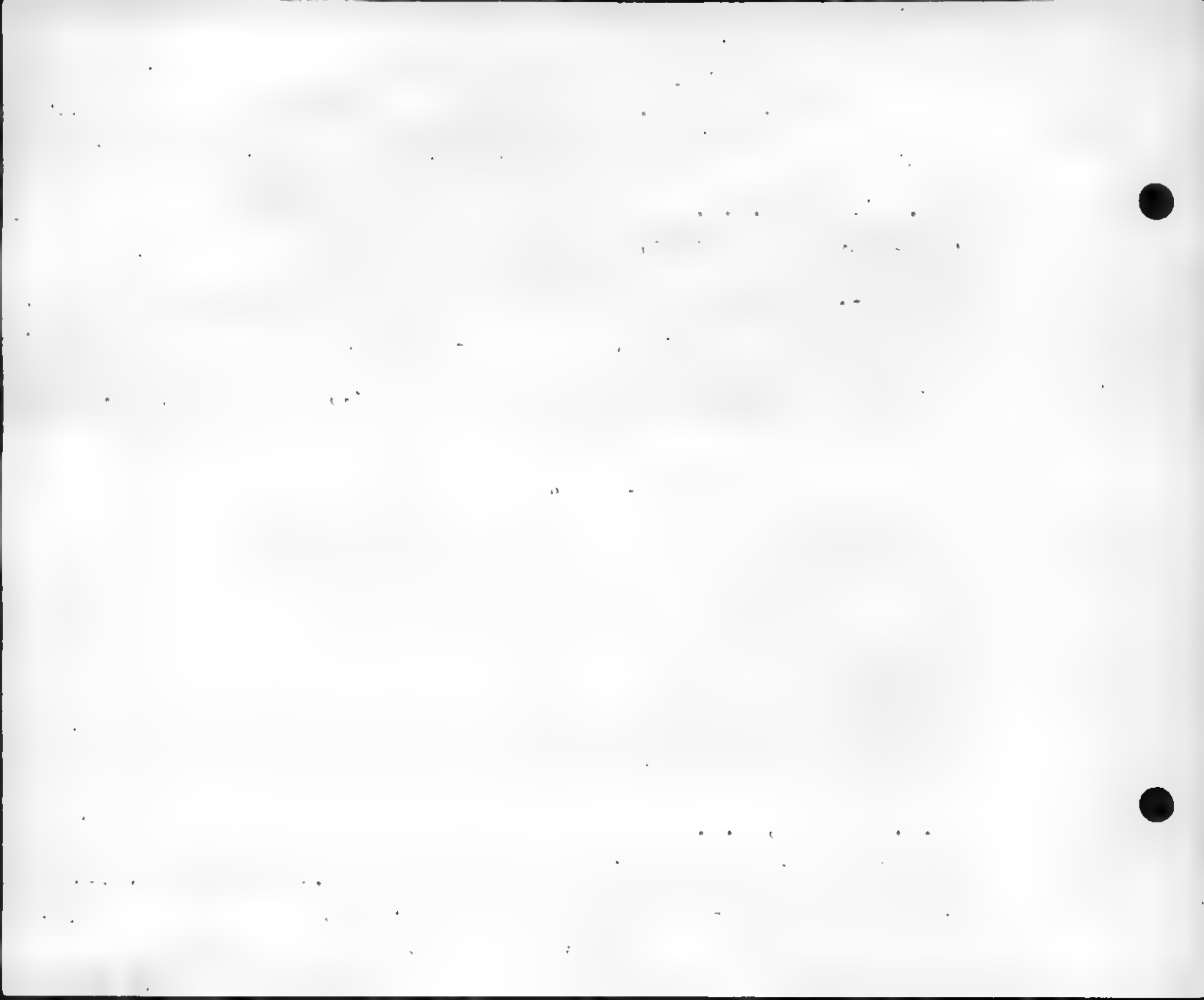
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16746					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1 DECEASED NAME (Type or Print)			First <b>MARY</b>			Middle <b>LINDSAY</b>			Last <b>LINDSAY</b>			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year <b>Dec. 8, 1968</b>		2b HOUR <b>11:30 PM</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>JUNE 22, 1899</b>		6 AGE (in years) <b>69</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year <b>December 8, 1968</b>		2d HOUR <b>11:30 PM</b>			
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>ALLEGANY</b> Md.						
10. CITY OR TOWN OF DEATH <b>FROSTBURG</b>				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>MINERS HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>				12b KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>				13b COUNTY <b>ALLEGANY</b>		13c CITY OR TOWN <b>FROSTBURG</b>		13d INS DE CITY, JIM IS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>ROUTE 1</b>					
14 FATHER'S NAME <b>JOHN LINDSAY</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>SARAH WILLIAMS</b>			First Middle Last						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)				16b SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT <b>JOHN A. LINDSAY, RT. 1, BOX 59, FROSTBURG, MD.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism, Massive</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Fracture of Right Femur</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 Days</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes, Chronic Glomerulonephritis, ASCV Disease</b>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>8:00-4 Dec. 4 19 68</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Fell at home</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home farm, street factory, office building, etc.) <b>Home</b>				21f. LOCATION Street or R.F.D. No City or Town County State <b>Rt. # 1, Frostburg, Allegany, Maryland</b>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>December 8, 1968</b> ADDRESS (Street, city, town, or county) <b>Alleg. Cumberland, Md.</b>				22b. DATE SIGNED							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>DEC. 11, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FBG. MEMORIAL PARK</b>				23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>					
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, FROSTBURG, MD. 21532</b>						ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 13 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

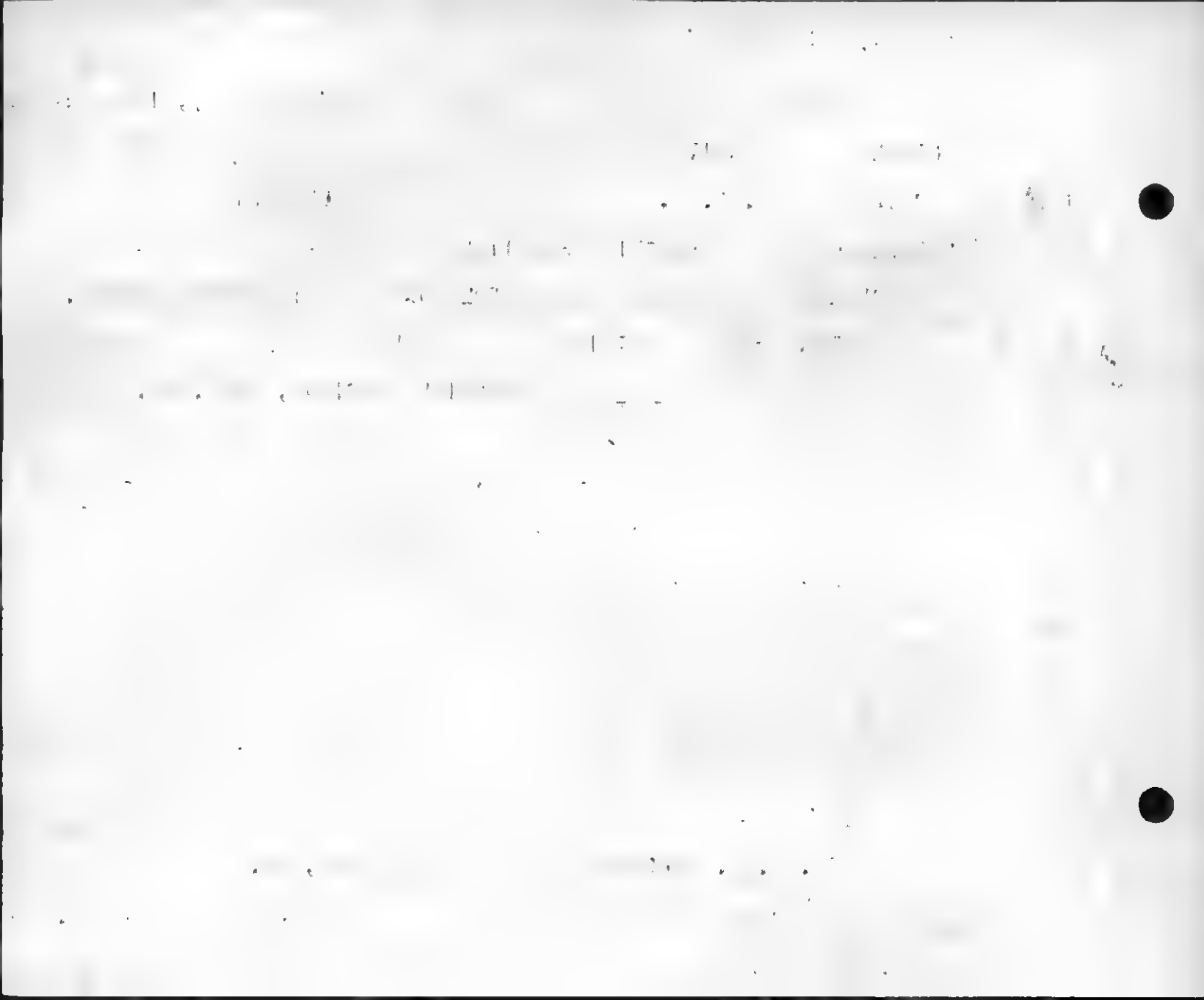
Item 13 Film 408 12/21/68 KK		MARYLAND STATE DEPARTMENT OF HEALTH							
Item 13 Film 408 1/15/69 KK		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201							
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH	Month	Day	Year	2b. HOUR
HOWARD		W.		MALCOLM	DECEMBER		11	68	4:00 M
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE	WHITE	10-13-99		69 YRS.		MONTHS DAYS		HOURS M N	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
W. VA.	U.S.A.			ALLEGANY		Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and city)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL				BREWERY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER			
W. VA. MD. Md. Alleg. Morgan		FALLS PAW		YES		R.F.D. 1, Paw Paw, W. Va.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
JACOB				MALCOLM	ELIZABETH				COX
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO		212 18 1636		MEMORIAL HOSP., CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
193X		IMMEDIATE CAUSE (a)		2d					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF		2 months					
194X		(b) Carcinomatosis to lungs, cervical nodes		2 months?					
		(c) Carcinoma of Thyroid							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)		Cerebrovascular heart disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11/10/68 to 12/11/68, that (I) (we) last saw the deceased alive on 12/11/68, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE S.G. WEISMAN, M.D.		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 12/11/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		59 GREEN ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		12/13/1968		Wesley Chapel Church		Levels, (Hampshire) W. Va.			
24. FUNERAL DIRECTOR Johnson F. Homes		ADDRESS Berkeley Springs, W. Va.		25a. REC'D BY REGISTRAR DATE DEC 19 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MIDDLE											
16735											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
16748											
1 DECEASED-NAME (Type or print)				First MARY Middle A Last MALIN				2a DATE OF DEATH			
3 SEX				4 RACE				5. DATE OF BIRTH			
FEMALE				WHITE				April 27, 1892			
7a BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				6. AGE (In years last birthday)			
OHIO				U. S. A.				76 YRS			
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH *				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
ALLEGANY											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			
CUMBERLAND				MEMORIAL HOSPITAL				HOUSEWIFE			
12b. KIND OF BUSINESS OR INDUSTRY				13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b. COUNTY			
SELF				MARYLAND				ALLEGANY			
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET AND NUMBER			
CUMBERLAND				NO <input type="checkbox"/>				418 WASHINGTON ST.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
First BYRON Middle REED Last SUTLIFF				First CLARA Middle ESTHER Last CARLTON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO				17 INFORMANT			
NO				217-42-6591				MEMORIAL HOSPITAL, CUMB. MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Terminal Cardiac arrest											
4101 DUE TO, OR AS A CONSEQUENCE OF Myocardial Infarction, acute, and myocardial											
(b) DUE TO, OR AS A CONSEQUENCE OF A.S. Cardiovascular Disease											
(c) 2 1/2 days 8 yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Chronic cholecystitis with cholelithiasis											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY			
								HOUR A.M. Month Day Year 19			
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			
				While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 19 68, to 7 Dec., 19 68, that (I) (we) last saw the deceased alive on 7 Dec. 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE											
W. A. Van Ormer, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22c. DATE SIGNED 7 Dec. 68											
22d. PHYSICIAN'S NAME (Type) DR. W. A. VANORMER											
22e. ADDRESS CUMBERLAND, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
Burial				12/10/1968				Hillcrest Burial Park			
23d. LOCATION (City or Town) (County) (State)				23e. REC'D BY REGISTRAR				23f. REGISTRAR'S SIGNATURE			
Near Cumberland Alleg Md				DEC 12 1968				John J. Hafer, Jr.			
24. FUNERAL DIRECTOR John J. Hafer, Jr., 230 Balto Ave, Cumberland Md											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
10736 CERTIFICATE OF DEATH 16749														
1. DECEASED-NAME (Type or print)			First MARY		Middle E.		Last MANLEY		2a. DATE OF DEATH Month 12 Day 19 Year 68		2b. HOUR 4:50 M			
3 SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 01-07-95			6. AGE (In years lost birthday) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY COUNTY, Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TEACHER			12b. KIND OF BUSINESS OR INDUSTRY TEACHER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY Allegany			13c. CITY OR TOWN MIDLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER O'MARASTREET, BOX 41			
14. FATHER'S NAME First Middle Last WILLIAM MANLEY			15. MOTHER'S MAIDEN NAME First Middle Last (LANGAN) CATHERINE MANLEY			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 212-38-5601			17. INFORMANT Address MD. 21502 SACRED HEART HOSPITAL, 900 SETON DR., CUMB.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENO-CARCINOMA, LEFT OVARY DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 MOS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from 5 - 6, 19 57 to 12 - 19, 19 68, that (I) (we) last saw the deceased alive on 12 - 18, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE R. W. Ballin M.D.								DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-19-68		
22d. PHYSICIAN'S NAME (Type) R.W. BALLIN, M.D.								22e. ADDRESS 62 GREENE ST., CUMBERLAND, MD. 21502						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/21.1968		23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery				23d. LOCATION (City or Town) (County) (State) Frostburg, Md.						
24. FUNERAL DIRECTOR EICHORN FUNERAL HOME-8 E. MAIN ST., LONA CONING MD.								25a. REGISTERED DEC 23 1968		25b. REGISTRAR'S SIGNATURE [Signature]				



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10737

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 6 Film G407 12/18/68 kk

CERTIFICATE OF DEATH

16750

1 DECEASED-NAME (Type or print) <b>ELIZABETH</b>		First <b>W.</b>		Middle <b>MARTIN</b>		Last		2a DATE OF DEATH <b>DEC.</b> Month <b>7</b> Day <b>1968</b> or				2b. HOUR <b>6:02 PM</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>DEC. 17, 1882</b>				6 AGE (In years last birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <b>ENGLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.							
10 CITY OR TOWN OF DEATH <b>FROSTBURG</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MINERS HOSPITAL</b>				12a USUAL OCCUPATION (Kind of work done during most of work up life, even if retired) <b>HOUSE WIFE</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>				13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>MT. SAVAGE</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
14 FATHER'S NAME First <b>RICHARD</b> Middle <b>WATKINS</b> Last				15. MOTHER'S MAIDEN NAME First <b>EDITH</b> Middle <b>JENKINS</b> Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. ELSIE BARB, MT. SAVAGE, MD.</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>1550</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Carcinoma of upper L.F. Tract</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Origin probably in hypos of liver.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>6 months</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1550. Generalized atherosclerosis, moderate.</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Peritoneal effusion.</b>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 8, 1968</b> , to <b>Dec 8, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 8, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE <b>Alvin J. Walters M.D.</b>								22c. DATE SIGNED <b>12/9/68.</b>					
22d. PHYSICIAN'S NAME (Type) <b>DR. ALVIN J. WALTERS</b>				22e. ADDRESS <b>48 BROADWAY, FROSTBURG, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>DEC. 11, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>METHODIST CEMETERY</b>				23d. LOCATION (City or Town) (County) (State) <b>MT. SAVAGE, MD.</b>					
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, FROSTBURG, MD. 21532</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



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VR A15 (10-66)  
30M REV. 1-68

1  
38  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16751

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
LOUISE		B.		MARTIN	DECEMBER 20, 1968		1:55PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH AUGUST 4, 1894		6. AGE (In years lost birthday)		7. YRS.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. MIN.
MARYLAND		USA				ALLEGANY		MD.
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
		SACRED HEART HOSPITAL		HOUSEWIFE		OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND		ALLEGANY		CUMBERLAND				C STREET, POTOMAC PARK
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
AJOHN				BRINKER	(POWERS)		ANNIE	BRINKER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT				
NO				HOSPITAL RECORD, CUMBERLAND, MD. 21502				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>								
203X DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>203X</u>								
(b) <u>Mucipic Myeloma</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
<u>Exposure to</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town
								County
								State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Clarence Vincent, M.D.</u>						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS		22c. DATE SIGNED
CLARENCE VINCENT, M.D.						126 N. SMALLWOOD ST., CUMBERLAND, MD.		Dec. 22, 1968
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)
Burial		Dec. 23, 1968		SS. Peter Paul Cemetery		Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
				DEC 26 1968		<u>Charles Judge</u>		

MEDICAL CERTIFICATION

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used in the study.

3. The third part is a discussion of the results of the study.

4. The fourth part is a conclusion and a list of references.

5. The fifth part is a list of the names of the authors and their institutions.

6. The sixth part is a list of the names of the reviewers and their comments.

7. The seventh part is a list of the names of the members of the committee.

8. The eighth part is a list of the names of the members of the committee.

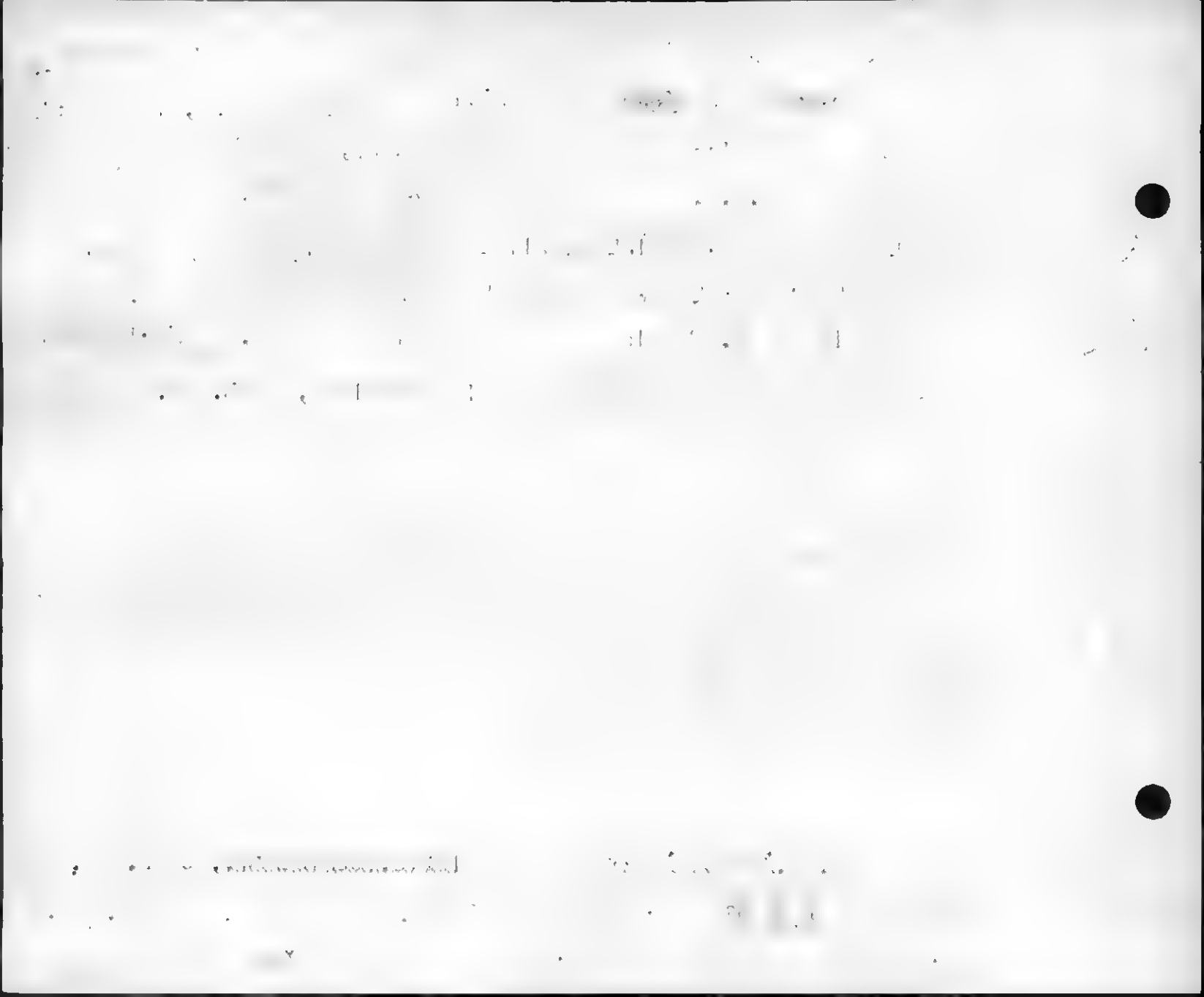
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MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH	Month	Day	Year	2b. HOUR
David		Scott	MARVIN		DECEMBER	28	1968	6:35	PM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE	WHITE		DECEMBER 27, 1958		— YRS.	MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				ALLEGANY Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital)		12a. USUAL OCCUPATION (Kind of work done during working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL		None		None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND				109 Frederick St.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
DAVID		S.	MARVIN		MARY		L.	Brittenham	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No		None		MEMORIAL HOSPITAL, CUMB. MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u>									
7782 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumothorax</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
7715									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		ROBERT D. BRODELL (DEGREE)				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		DR. XXXXXXXXXX				22e. ADDRESS		XXXXXXX CUMB. MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/12/69		Hillcrest Burial Park		Cumberland, Allegany Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
H. Wayne George Cumberland, Maryland				JAN 2 1969		Charles Judge			

304 REV 1/68



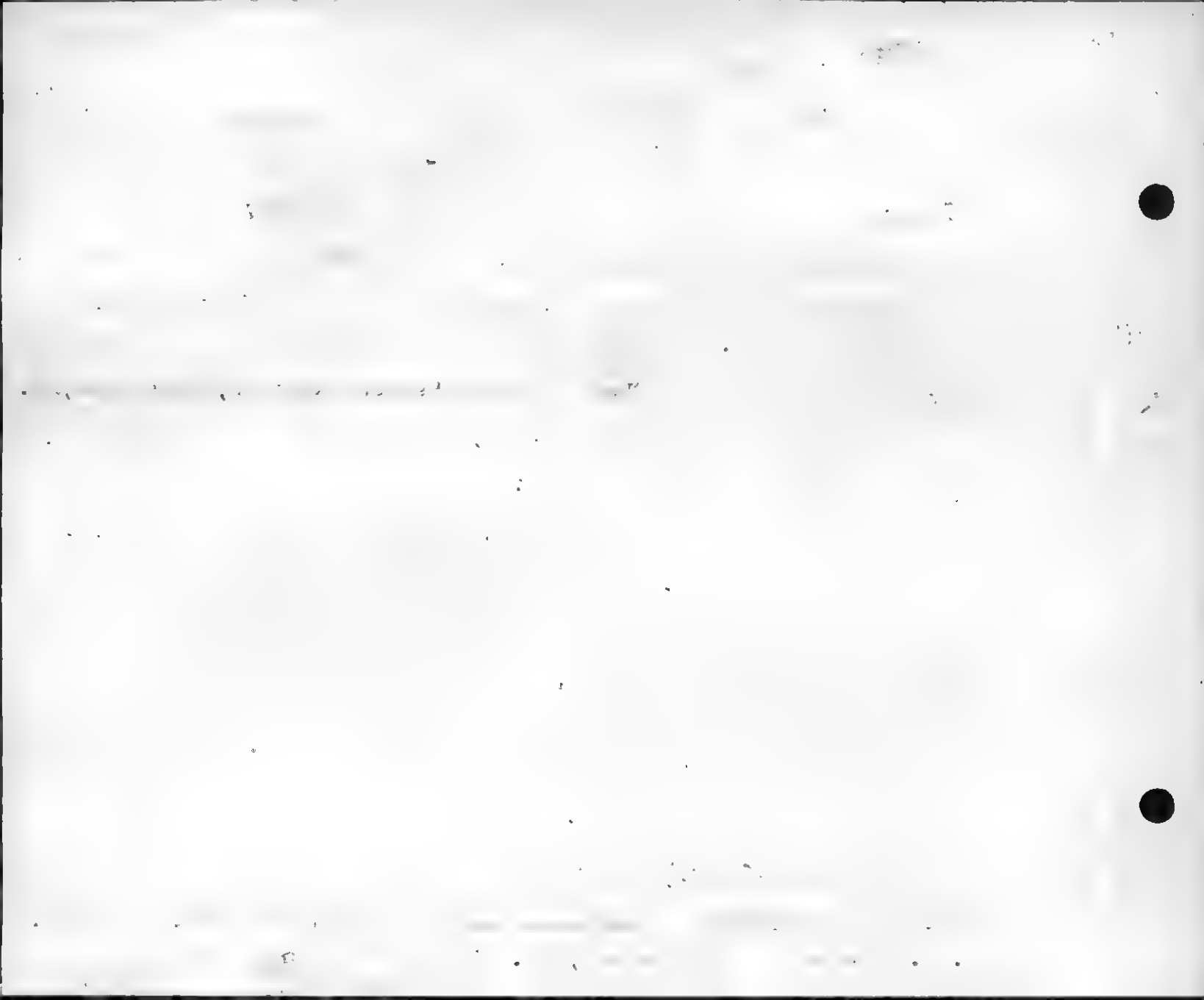
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
16740  
CERTIFICATE OF DEATH

16753

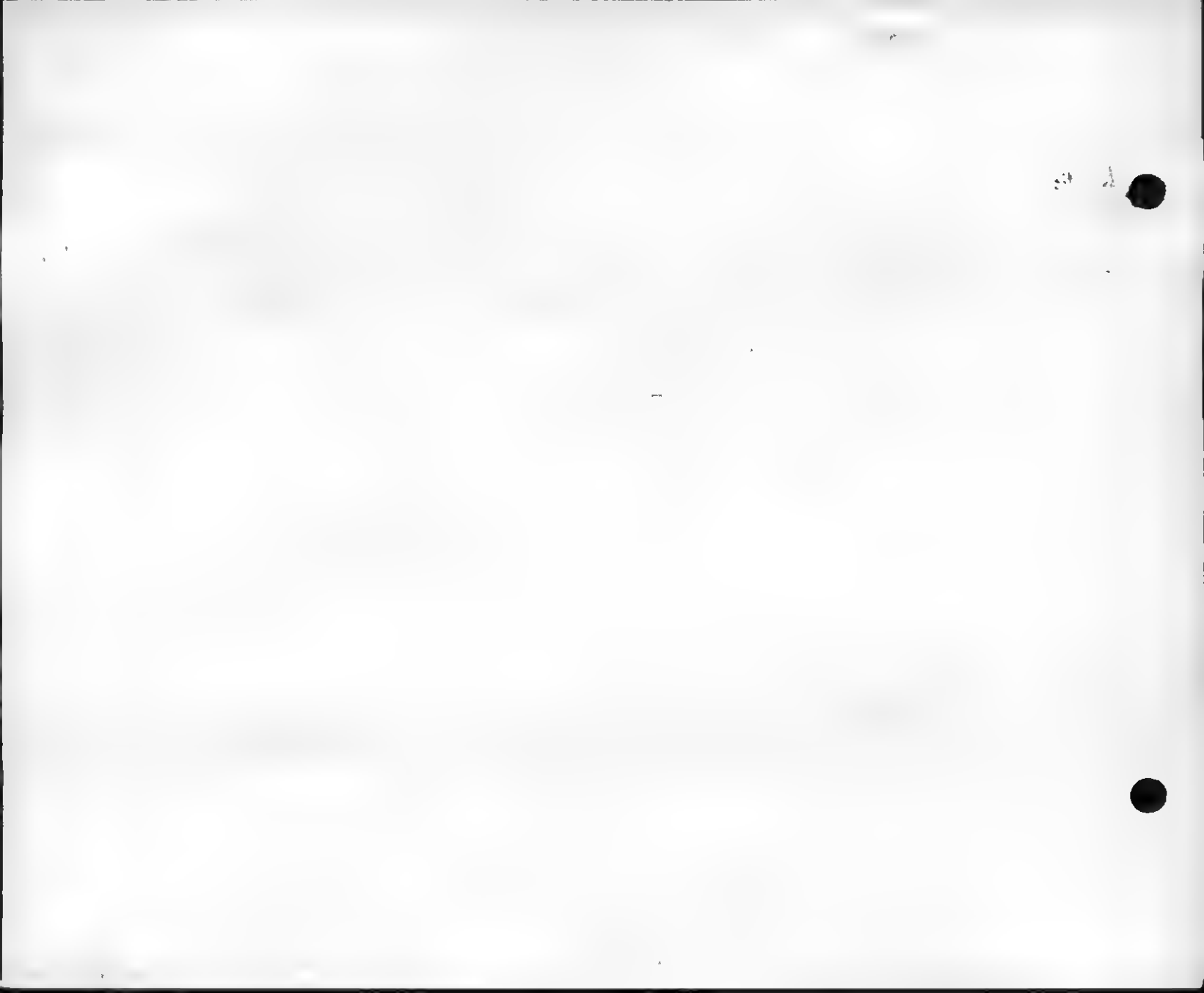
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR		
John		William	McCorkle	December	Day 25	Year 1968	4:14	PM	
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male	White		May 8, 1882		86 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8- MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Penna		USA				Allegany Md.			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Cumberland		Sylvan Retreat		None		None			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Allegany		Cumberland				952 Glenwood Street	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME		Address				
First Middle Last			First Middle Last						
Peter H. McCorkle			Margaret Clark						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT					
NO		None		Sylvan Retreat Records, Cumberland, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Encephalitis</u>								approx 3 days	
4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chr. ASMR</u>								many years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Anterior Sclerosis</u>								many years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH-BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Barbiturate Poisoning</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr. 15, 1967</u> , to <u>Dec. 25, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec. 24, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Walter Lupper</u> M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c DATE SIGNED <u>12.30.68</u>			
22d PHYSICIAN'S NAME (Type) <u>Walter Lupper</u>						22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL		12/29/68		Henderson Cemetery		Harmer Twnshp. Penna.			
24. FUNERAL DIRECTOR A. M. Clowes				ADDRESS Springdale, Pa. 15144		25a. REC'D BY REGISTRAR DATE JAN 2 1969			
						25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH																
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
CERTIFICATE OF DEATH																
1. DECEASED NAME (Type or print)			First JOHN			Middle W.			Last Mc CULLOUGH			2a. DATE OF DEATH DEC. Month 22 Day 1968 Year			2b. HOUR M	
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH JULY 25, 1886			6. AGE (In years last birthday) 82 YRS			7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 MRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY			Md.				
10. CITY OR TOWN OF DEATH FROSTBURG			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED MAIL CARRIER			12b. KIND OF BUSINESS OR INDUSTRY GOV'T.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN FROSTBURG			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 179 E. MAIN STREET				
14. FATHER'S NAME First Middle Last WILLIAM W. McCULLOUGH						15. MOTHER'S MAIDEN NAME First Middle Last ESTELLE HORNE										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)						16b. SOCIAL SECURITY NO. 266-76-9394			17. INFORMANT Address M. M. McCULLOUGH, FROSTBURG, MD. 21532							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Hemorrhage 431.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 351X (b) Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours years																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Carcinoma of Prostate Chronic Pul. Fibrosis																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from NOV 21, 1968, to Dec 22, 1968, that (I) (we) last saw the deceased alive on Dec 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Leslie Miles M.D.			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 12.23.68							
22d. PHYSICIAN'S NAME (Type) DR. LESLIE MILES			22e. ADDRESS LONACONING, MD.													
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL			23b. DATE DEC. 26, 1968			23c. NAME OF CEMETERY OR CREMATORY MERCER CITIZENS CEMETERY			23d. LOCATION (City or Town) (County) (State) MERCER, PA.							
24. FUNERAL DIRECTOR J. R. DURST, FROSTBURG, MD. 21532			ADDRESS			25a. REC'D BY REGISTRAR DEC 27 1968			25b. REGISTRAR'S SIGNATURE Charles Judge							



FOR STATE  
HEALTH DEPT.

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16742

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16755

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
PATRICK		RAYMOND	McGEADY			DEC.	2	19	68	830P
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR		
MALE	WHITE	MAY 8, 1898	70 YRS	MONTHS	DAYS	DECEMBER		Day	2	Year 19 68 830P
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md		
OCEAN, MARYLAND		USA				ALLEGANY				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during last period of activity)		12b KIND OF BUSINESS OR OCCUPATION				
CUMBERLAND		MEMORIAL HOSPITAL-DOA		RETIRED PAINTING		CONTRACTOR				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
MARYLAND		ALLEGANY		CUMBERLAND				303 DECATUR STREET		
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
JOHN		J.	McGEADY	JULIA		CAVANAUGH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
NO		218-10-9929A		MRS SARAH McGEADY		303 DECATUR ST CUMBERLAND				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION										SUDDEN
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) CORONARY SCLEROSIS										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
420										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. P.M. 19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No.		City or Town		County		State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Benedict Skitarcelic		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED		
EXAMINER'S NAME (Type)		BENEDICT SKITARCELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DECEMBER 3, 1968		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) CUMBERLAND, MD.		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
BURIAL		DEC 5, 1968		ST. PETER & PAUL CATH. CEMT.		CUMBERLAND		ALLEGANY		MD.
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
SILCOX-MERRITT FUNERAL SERVICE		404 DECATUR ST CUMBERLAND, MARYLAND		DEC 5 1968		f Charles Judge				

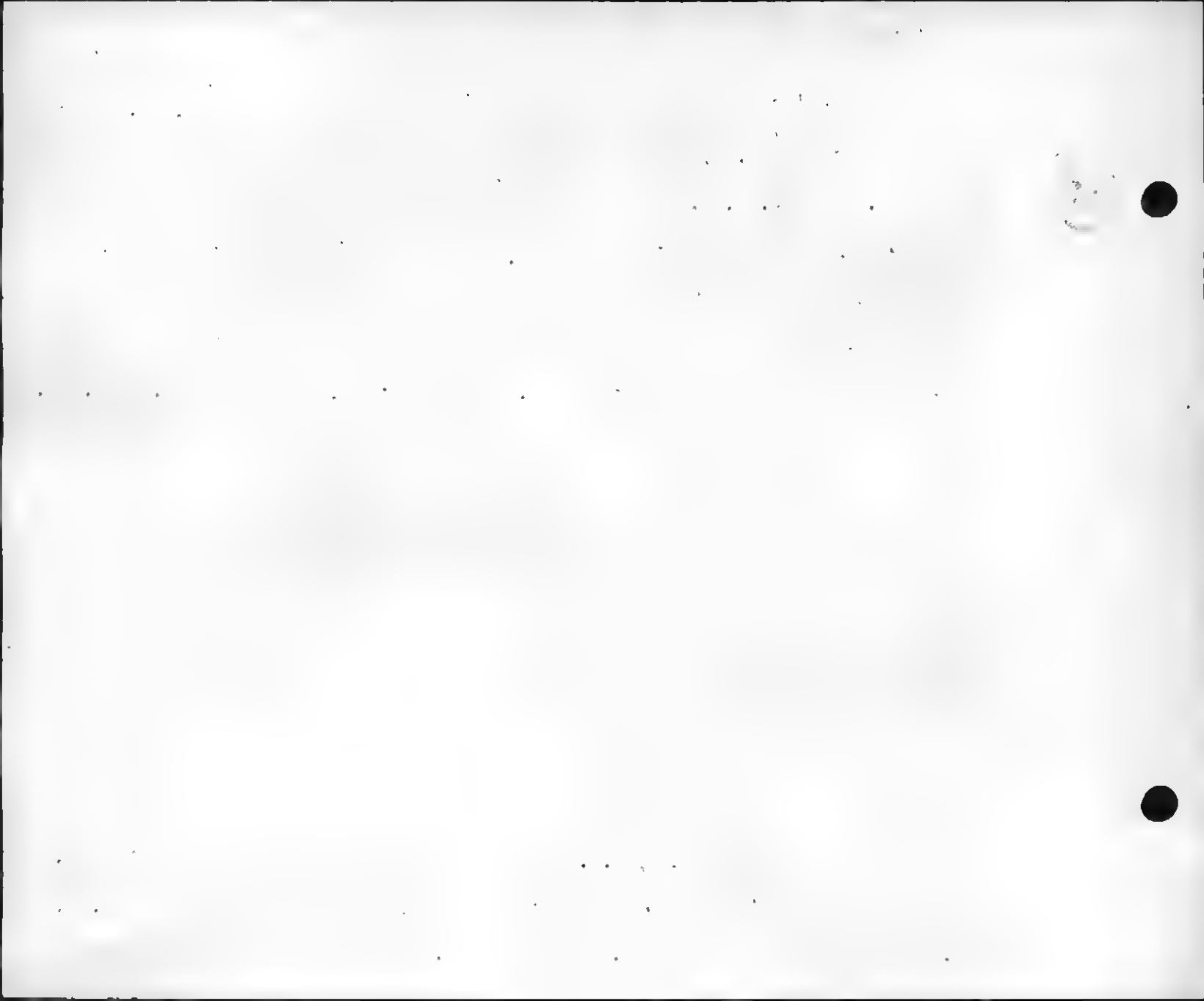


# FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Jean'ne			Thelma			McKeivier			Dec. 21, 1968 2:40am		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years and birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD			2d HOUR
Female	White	Aug. 1, 1939	29 YRS					December 21, 1968			2:40a M
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Penna.			U. S. A.						Allegany Md.		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Cumberland			SACRED HEART HOSP. DOA			Housewife & Hostess			Restaurant		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13e STREET AND NUMBER		
Maryland			Allegany			Cumberland			205 Sunset Drive,		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO		
James			Rhinehart			Freda			21502		
									L. Karl McKeivier, 205 Sunset Dr. Cumb. Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 9520 DUE TO, OR AS A CONSEQUENCE OF Card trans, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CARBON MONOXIDE POISONING DUE TO, OR AS A CONSEQUENCE OF (c) (AUTO EXHAUST--SUICIDE)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 Minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7721											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED		
Benedict Skitarelic									DECEMBER 21, 1968		
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER			CUMBERLAND, MARYLAND		
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Cremation			12/23/68			Fort Lincoln Crematory,			Washington, D. C.		
24. FUNERAL DIRECTOR			ADDRESS			25. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
H. Wayne George			202 Greene St. Cumberland, Md.			DEC 26 1968			Charles Judge		



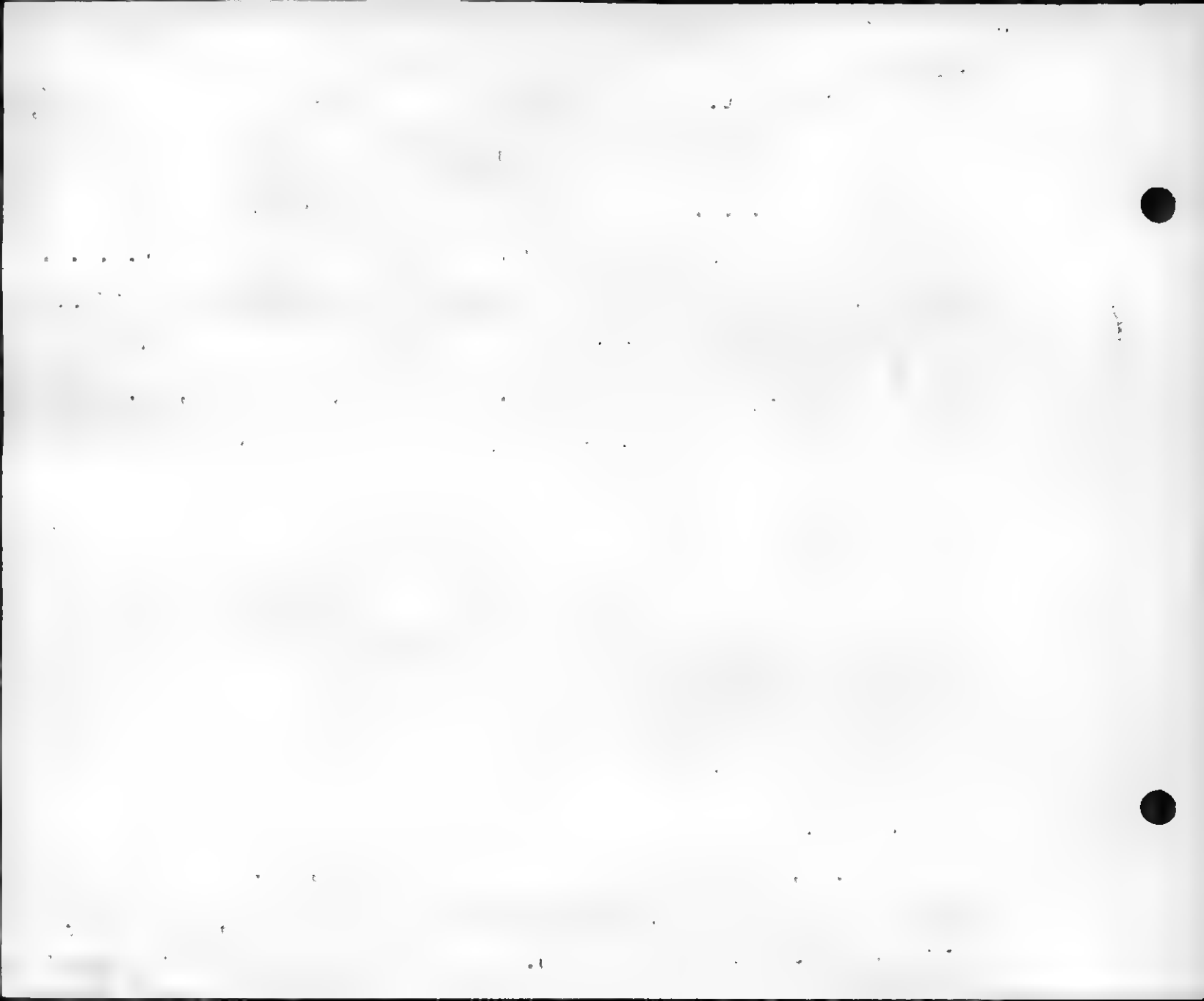
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16744  
16757

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

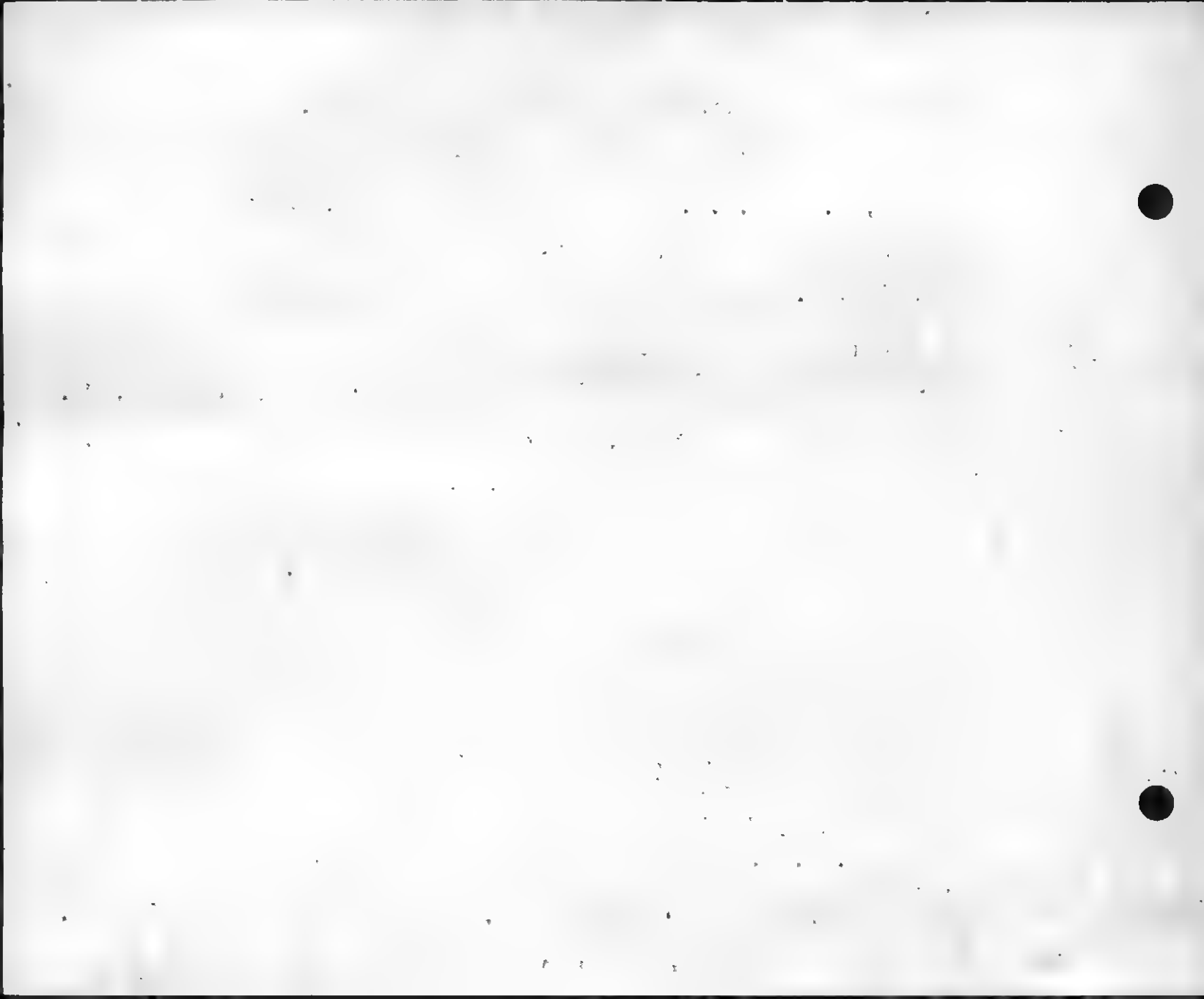
1 DECEASED NAME (Type or print) <b>IRVIN</b>		First <b>C.</b>	Middle	Last <b>MERICA</b>	2a. DATE OF DEATH <b>12-8-1968</b>		Day	Year	2b. HOUR <b>12:40</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>1-28-1927</b>		6 AGE (In years last birthday) <b>41</b>		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>				
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY <b>B.O.R.R.</b>				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>		13b COUNTY <b>ALLEGANY</b>		13c CITY OR TOWN <b>CUMBERLAND</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>828 LAFAYETTE AVE.,</b>		
14. FATHER'S NAME First <b>JOHN</b>		Middle	Last <b>MERICA</b>	15. MOTHER'S MAIDEN NAME First <b>ESSIE</b>		Middle	Last <b>BAKER</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b>		(If yes give war or dates of service) <b>War II</b>		16b SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. June Merica, Cumberland, Md.-Wife</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia (Superior Sulcus Tumor), Rt Lung</b> <b>1661</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Uncertain</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1.</b>										
19a DATE OF OPERATION <b>None</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 20, 1968</b> , to <b>Dec. 8, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 8, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>Calvin Y. Hadidian</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-9-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>DR. C.Y. HADIDIAN</b>						22e. ADDRESS <b>CUMBERLAND, MD.</b>				
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>Dec. 10, 1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Mt. Herman Cemetery</b>		23d. LOCATION (City or Town)		(County)	(State)	
						<b>Cumberland, Allegany, Md.</b>				
24 FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						25a REC'D BY REGISTRAR DATE <b>DEC 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, within 72 hours after death.

16745										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16758									
Item 2, Film G407 12/23/68 kk										CERTIFICATE OF DEATH																			
1. DECEASED NAME (Type in full) <b>THOMAS</b>					First <b>ISAAC</b>					Middle <b>METZ</b>					Last <b>METZ</b>					2a. DATE OF DEATH Month <b>7</b> Day <b>1968</b>					2b. HOUR <b>1:25</b> AM				
3 SEX <b>MALE</b>					4. RACE <b>WHITE</b>					5. DATE OF BIRTH <b>10-14-1894</b>					6. AGE (In years last birthday) <b>74</b> YRS.					IF UNDER YEAR MONTHS <b>74</b>					IF UNDER 24 HRS HOURS <b>1</b> MIN				
7a. BIRTHPLACE (State or foreign country) <b>BARTON, M.</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>ALLEGANY</b> Md														
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>														
13a. USJA. RESIDENCE (Where deceased lived, if institution. Residence before admission) <b>BARTON, MD.</b>					13b. CITY <b>ALLEGANY</b>					13c. CITY OR TOWN <b>BARTON</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER <b>BOX 265</b>									
14. FATHER'S NAME First <b>WILLIAM</b>					Middle <b>METZ</b>					Last <b>ELLAN</b>					15. MOTHER'S MAIDEN NAME First <b>ELLAN</b>					Middle <b>POLAND</b>					Last <b>POLAND</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) <b>no</b> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. <b>183 01 8332</b>					17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Staphylococcal Septicemia</b> 4 <b>4</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>Vaccine Eryema &amp; Ulcer</b> (b) <b>1 month</b> DUE TO, OR AS A CONSEQUENCE OF (c)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2</b> <b>1 month</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes</b> <b>Arteriosclerosis</b> <b>HT</b> <b>Ascar</b>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)																			
21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (i) (this hospital) attended the deceased from <b>12/6</b> , 19 <b>68</b> , to <b>12/6</b> , 19 <b>68</b> , that (i), (we) last saw the deceased alive on <b>12/6</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) did not view the body after death.																													
22b. SIGNATURE <b>DR. S. G. WEISMAN</b>										DEGREE <b>DR.</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>12/7/68</b>									
22d. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>										22e. ADDRESS <b>CUMBERLAND, MARYLAND</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE <b>12/9/68</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cem.</b>					23d. LOCATION (City or Town) (County) (State) <b>Moscow Mills, Allegany Md.</b>														
24. FUNERAL DIRECTOR <b>Boal Funeral Home</b>										Main St. ADDRESS <b>Westernport, Md. 21562</b>					25a. REC'D BY REGISTRAR <b>DEC 13 1968</b>					25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>									



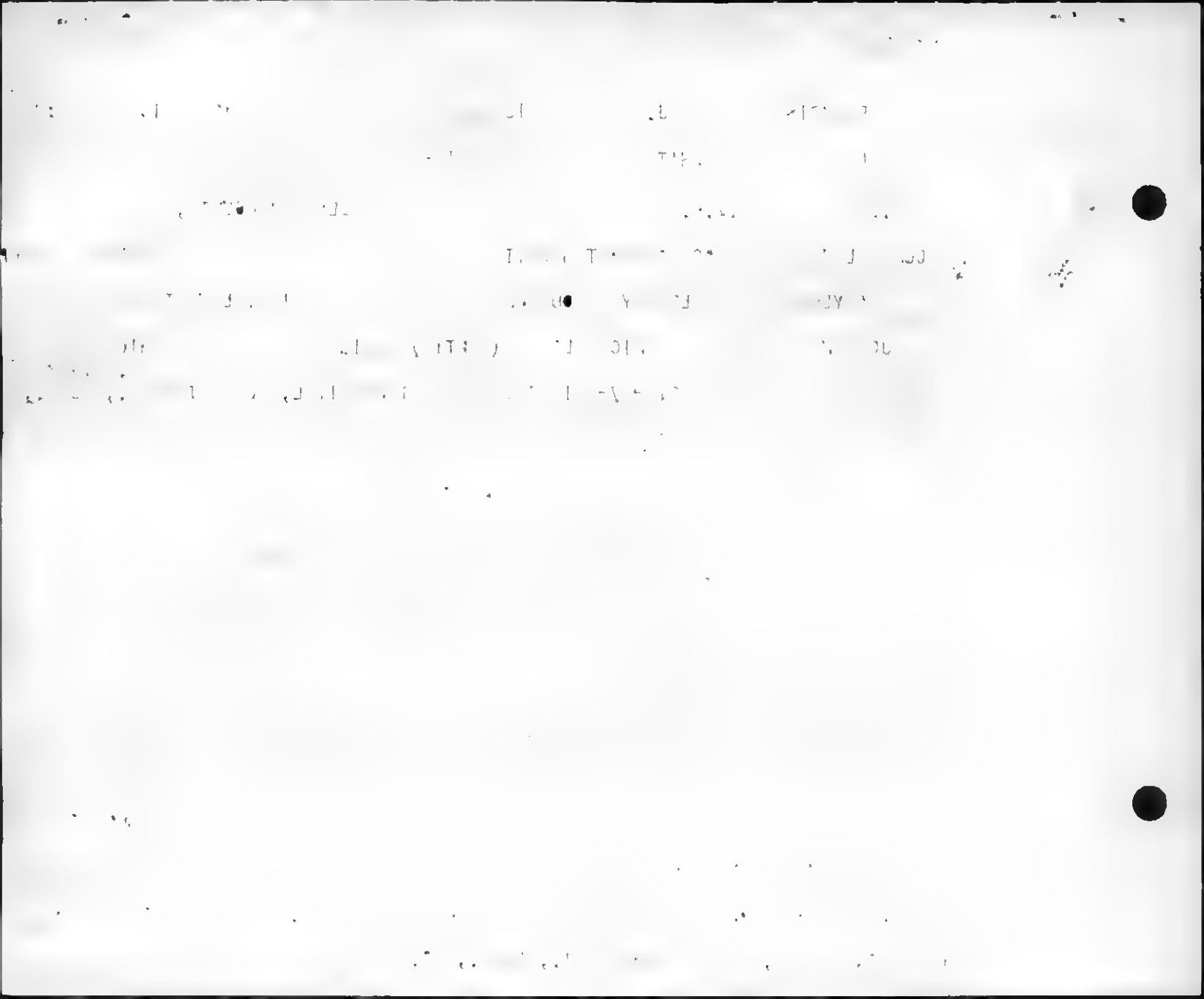
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VA 15-14  
30M REV 1-59

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>FRANCIS J. MICHAELS</b>						2a. DATE OF DEATH Month Day Year <b>12 18 68</b>			2b. HOUR A <b>5:07 M</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>06-18-00</b>			6. AGE (In years last birthday) <b>68 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ALLEGANY COUNTY, Md.</b>				
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CELANESE CORP.</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>531 DILLEY STREET</b>			
14. FATHER'S NAME First Middle Last <b>JOSEPH MICHAELS</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>(MARTIN) ANNIE MICHAELS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-07-3010</b>		17. INFORMANT <b>SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,</b>				Address <b>MD. 21502</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Cirrhosis of the Liver</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 11</u> , 19 <u>68</u> , to <u>Dec 18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Dec 18</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Clarence J. Vincent M.D.</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>12/20/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Clarence J. Vincent.</u>						22e. ADDRESS <u>Seton Drive</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>12/20/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memo Ph.</u>			23d. LOCATION (City or Town) (County) (State) <u>Cumberland Md.</u>				
24. FUNERAL DIRECTOR <u>STEIN FUNERAL HOME, 117 FREDERICK ST., CUMB.,</u>						25a. REC'D BY REGISTRAR <u>DEC 23 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Vincent</u>			

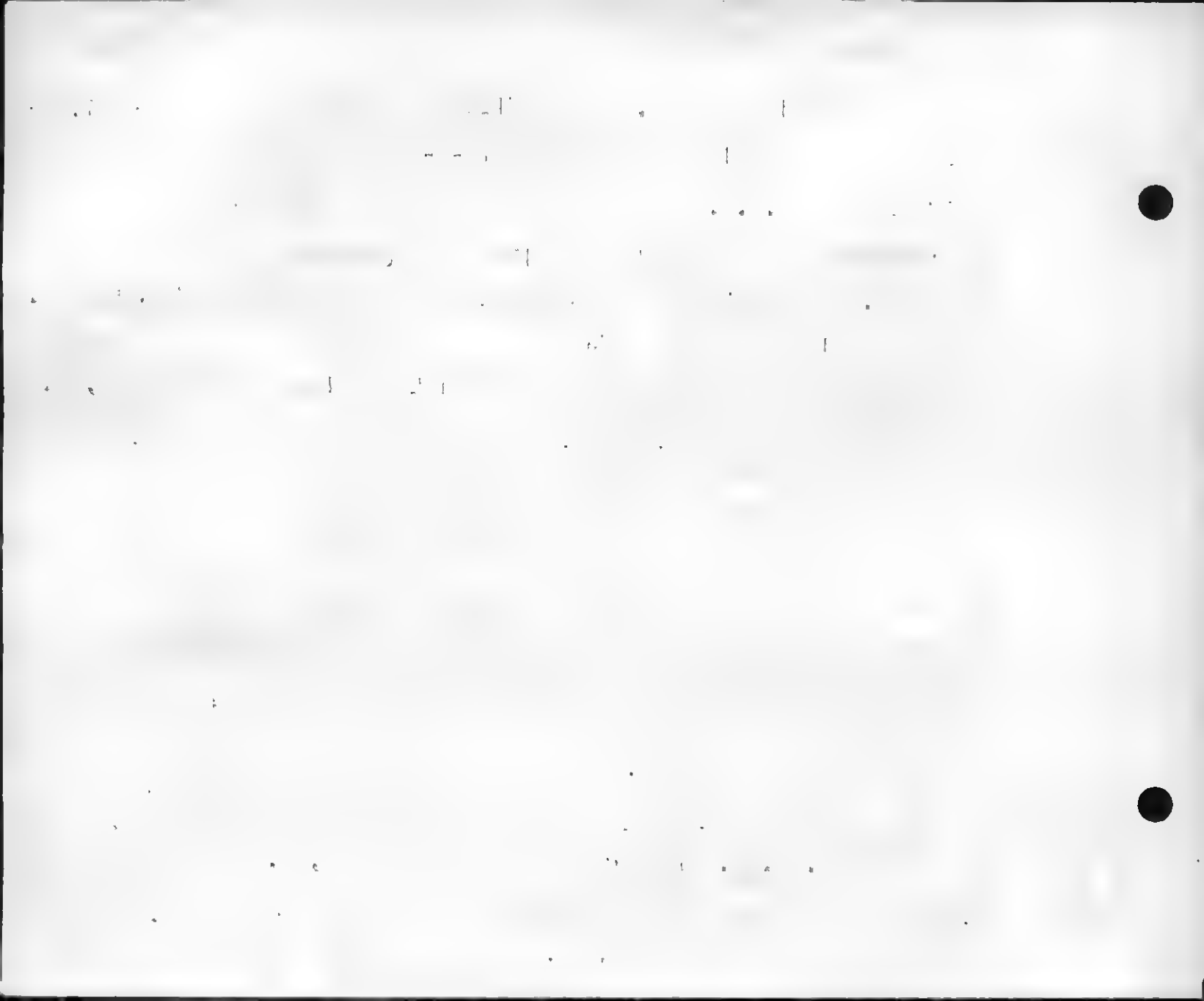
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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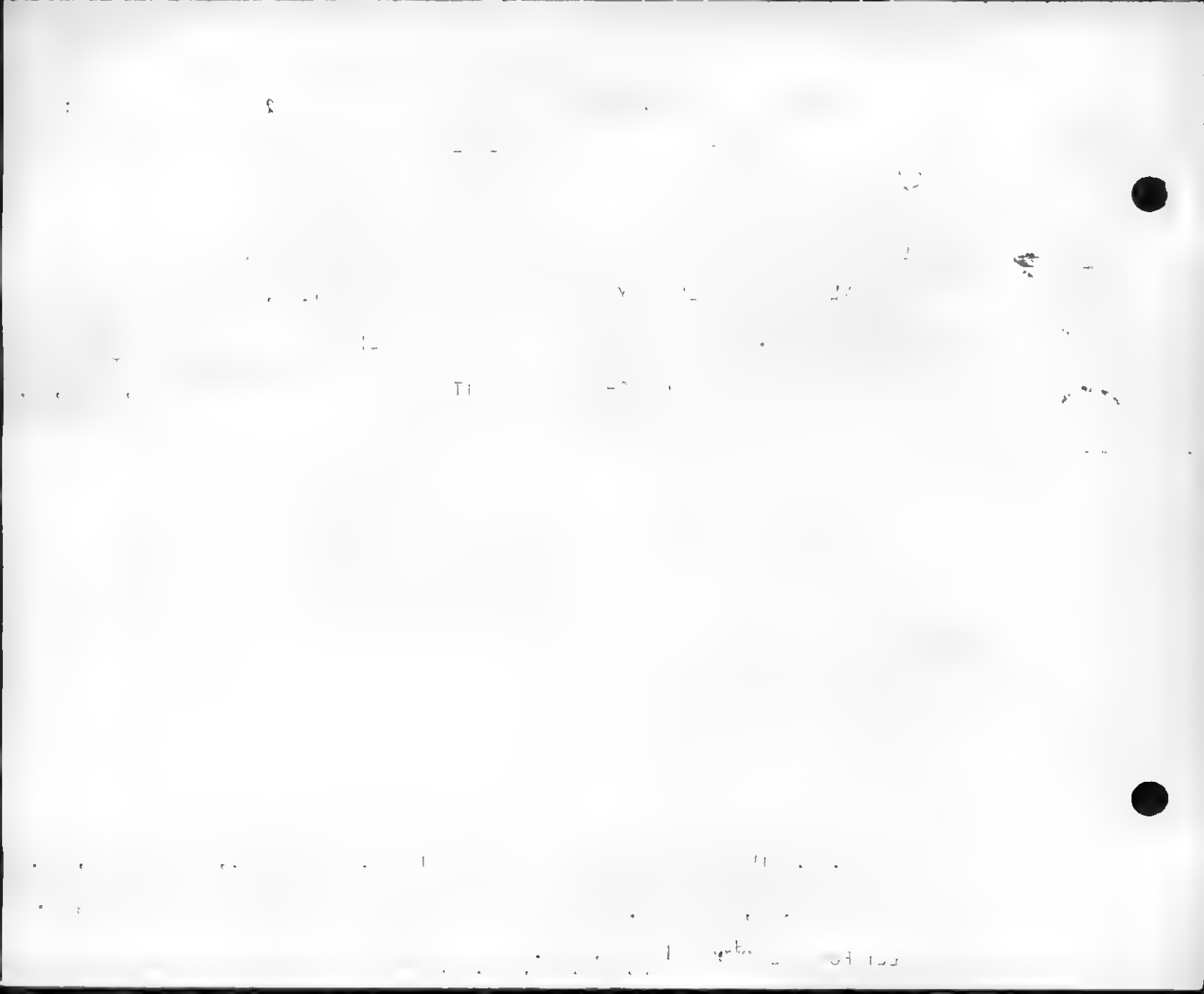
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
16747 CERTIFICATE OF DEATH 16760										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
BESSIE			P. MILLER			12 28 68		1:45 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
FEMALE		WHITE		11-2-91		77 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		U.S.A.				ALLEGANY Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL HOSPITAL			HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.			ALLEGANY		CUMBERLAND				25 PENNSYLVANIA AVE.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
DAVID S MANN			MARY E CREEK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
					MEMORIAL HOSPITAL		CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary - 1.40 AM</u>									11/28/68	
188X DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
1810										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>12/1/68</u> to <u>12/28/68</u> , that (I) (we) lost soul the deceased alive on <u>12/28/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>W. A. Himmler</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>								22c. DATE SIGNED <u>12/28/68</u>		
22d. PHYSICIAN'S NAME (Type) DR. W. A. HIMMLER								22e. ADDRESS CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Dec. 31, 1968		Fairview Cemetery		Near Artemas, Pa.				
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE JAN 6 1969		25b. REGISTRAR'S SIGNATURE <u>James F. Scarpelli</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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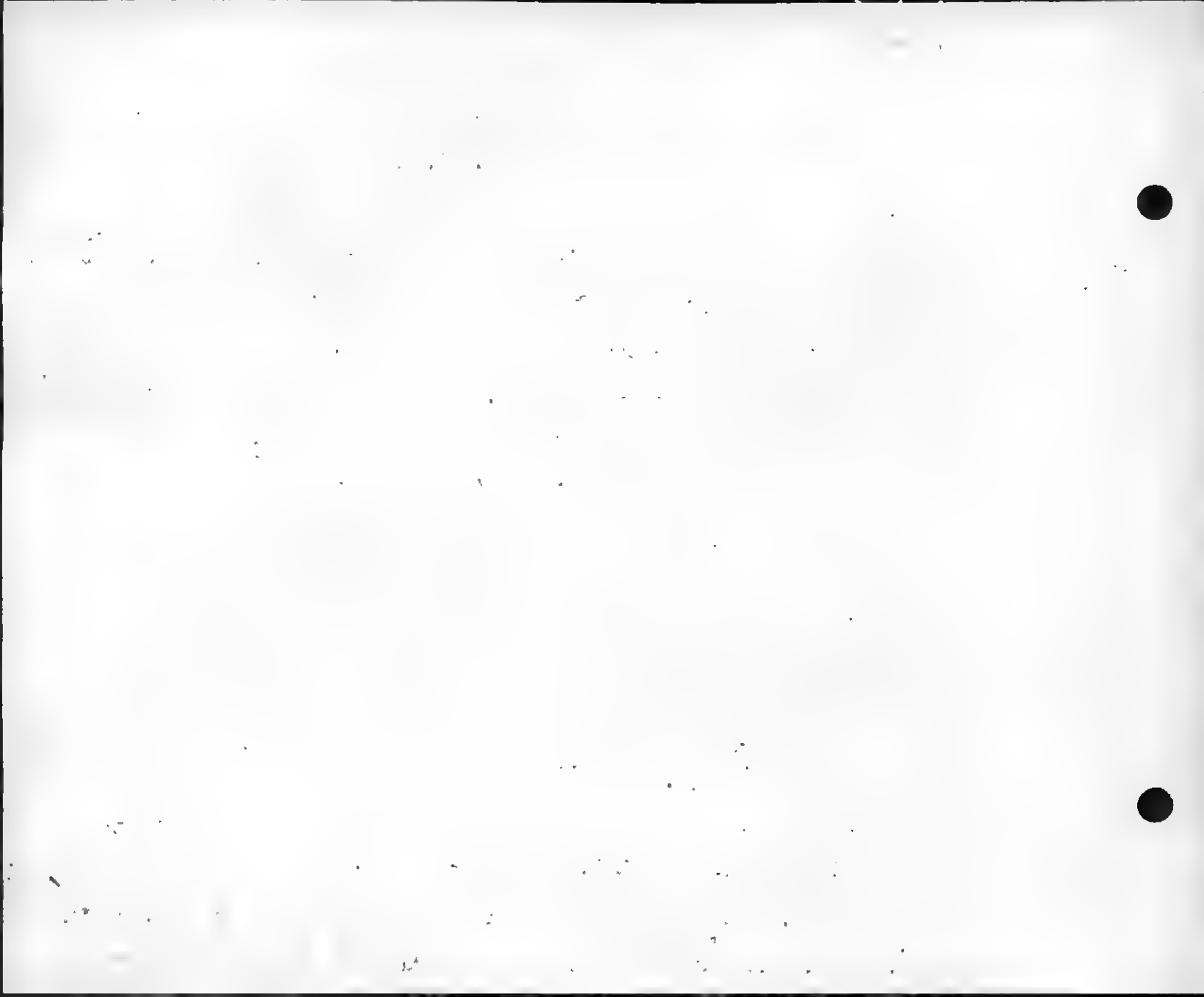
16748										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16761									
CERTIFICATE OF DEATH																													
1 DECEASED NAME (Type or print)			First JOHN			Middle M. (ROY)			Last MINKE			2a. DATE OF DEATH 12 Month 9 Day 68 Year				2b. HOUR 2:55 P M													
3 SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 8-27-03				6 AGE (In years lost birthday) 65 YRS				7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN													
7a BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH ALLEGANY Md.																			
10 CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SWIMMING POOL OWNER				12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED																			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER RT.#4, BOX 405																		
14 FATHER'S NAME First Middle Last (MIKE) MICHAEL J. MINKE			15. MOTHER'S MAIDEN NAME First Middle Last ELIZABETH MINKE																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b SOCIAL SECURITY NO. (If yes give war or dates of service) 214-32-3457			17 INFORMANT SACRED HEART HOSPITAL HOSPITAL RECORDS 900 SETON DRIVE, CUMB, MD.																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Widespread metastatic malignant</u> 1729 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mos																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1.																													
19a DATE OF OPERATION Sept 67			19b CONDITION FOR WH CH OPERATION WAS PERFORMED Same			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify med cal examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or RFD No City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>67</u> , to <u>9 Dec</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8 Dec 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																													
22b SIGNATURE <u>Miltenberger</u>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED 11 Dec 68																				
22d. PHYSICIAN'S NAME (Type) DR. F. MILTENBERGER			22e ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.																										
23a BURIAL CREMATION Burial (Specify)			23b DATE Dec. 12, 1968			23c NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery				23d LOCAT ON (City or Town) (County) (State) Cumberland, Allegany, Md.																			
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME			ADDRESS 108 VA. AVE. CUMBERLAND, MD. 21501			25a. REC'D BY REGISTRAR DEC 16 1968				25b REGISTRAR'S SIGNATURE J Charles Judge																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
William Earnest Mooney						Month Day Year 12 15 1968			8:30 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR MONTHS DAYS
Male		White		Nov. 27, 1893			75 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Ohio		U S A				Allegany Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Frostburg			Miners Hospital			Retired Mill Rite			Copperweld Co.
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Allegany		Frostburg		YES <input type="checkbox"/> NO <input type="checkbox"/>		94 Frost Village
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
George Mooney			Ida Kyle						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
Yes			WW 2		Mrs. Katherine Mooney 94 Frost Village				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROX. MATE. INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracerebral hemorrhage.									24 hr.
4120 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Cerebral atherosclerosis									6 yr.
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive cardiovascular disease									25 yr.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
443X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
1965		Carcinoma of rectum			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec 14, 1968, to Dec 15, 1968, that (I) (we) last saw the deceased alive on Dec 14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
Alvin J. Walters MD. DEGREE						12/17/68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
Alvin J. Walters, M. D.						48 Broadway, Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Dec. 18, 1968		Sunset Memorial Park		Near Cumberland Alleg Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John J. Hafer, Jr.						DEC 20 1968		Charles Judge	
230 Balto Ave. Cumberland									



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16750		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				16763	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print)		First		Middle		Last	
MARY		LOU		MORT			
3 SEX		4 RACE		5. DATE OF BIRTH		2a DATE OF DEATH	
FEMALE		WHITE		06-25-27		12 Month 19 Day 68 Year	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6 AGE (In years last birthday)	
MARYLAND		US OF A				41 YRS.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		SACRED HEART HOSPITAL		HOUSEWIFE			
13a USUAL RESIDENCE (Where deceased lived admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
MARYLAND		ALLEGANY		FROSTBURG		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO	
JOHN		MARY		NO		298-03-6360	
17 INFORMANT		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))		19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
SACRED HEART HOSPITAL RECORDS		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Retrosperitonal Sarcoma with generalized abdominal + left pleural metastases</i>					
900 SEYMOUR DRIVE, CUMBERLAND, MD.		(b) _____					
		(c) _____					
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
		HOUR AM Month Day Year					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from 12-16, 1968, to 12-19, 1968, that (I) (we) last saw the deceased alive on 12-19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE		22c DATE SIGNED			
		Andrew Stasko M.D.		12-19-68			
22d PHYSICIAN'S NAME (Type) ANDREW STASKO, M.D.		22e ADDRESS		401 DECATUR ST., CUMBERLAND, MD.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		12-29-68		FROSTBURG		FROSTBURG, ALLEGANY, MD.	
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
John J. Hafer, Jr. 230 Balto Ave. Cumberland ME		DEC 23 1968		Charles Judge			

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

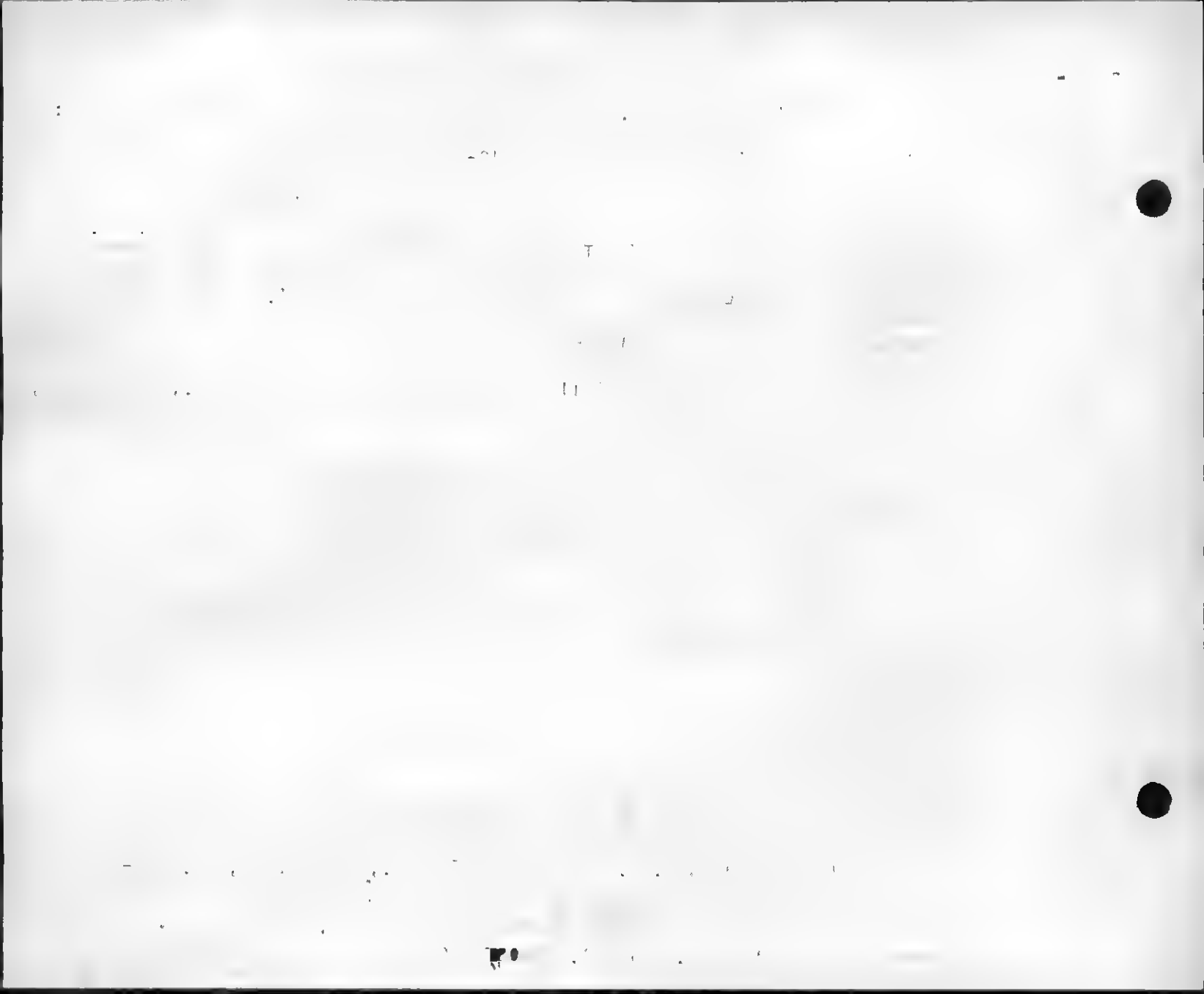
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16764					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year			2b HOUR OF ESTI- DEATH MATED <input type="checkbox"/> Dec. 25, 1968 7a			
MARY JANE MOWEN															
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR			
FEMALE		WHITE		JAN 16, 1886		82 YRS		MONTHS DAYS HOURS MIN		December 25, 1968 7		30a			
7a BIRTH-PLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			Md			
RHODE ISLAND			USA						ALLEGANY						
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY						
RFD# 2 FLINTSTONE MD.			AT HOME			HOUSEWIFE			HOUSEWIFE						
13a USUAL RES DENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY (Lat 1st?)			13e STREET AND NUMBER			
MARYLAND			ALLEGANY			RFD# 2 FLINTSTONE			NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>			RED# 2 BOX #153			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME												
HENRY KIDD SPENCE			CATHERINE TODD												
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS						
NO			NONE			WILBERT L. MOWEN			RED# 2 FLINTSTONE MD. BOX 153						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										CORONARY OCCLUSION			SUDDEN		
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										CORONARY SCLEROSIS			---		
(b)															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
4201															
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
CAUSE OF DEATH			HOUR A.M. P.M.												
22a INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			22b PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			22c LOCATION Street or R.F.D. No			City or Town			County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE			Benedict Skitarelic			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED			
EXAMINER'S NAME (Type)			Benedict Skitarelic, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			December 25, 1968						
						ADDRESS (Street, city, town, or county)			Cumberland, Maryland						
23a BURIAL, CREMATION REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)			(County) (State)			
BURIAL			28 DEC 68			PLESANT GROVE CEMETERY			RFD# 2 FLINTSTONE ALLEGANY MD						
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE						
H. LEE SILCOX			404 DECATUR STREET CUMBERLAND MD.			DATE DEC 27 1968			Charles Judge						



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16752										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16765															
1 DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR															
CLARENCE E. NEILSON										Month 12 Day 29 Year 68										5:08AM															
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)			7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
MALE			WHITE			12-24-29			39 YRS			MARYLAND			USA						ALLEGANY			CUMBERLAND			SACRED HEART HOSPITAL			FOREMAN			PAPER MILL		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER			14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address					
MARYLAND			ALLEGANY			FROSTBURG			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			RT. 1, BOX 107 B			MARSHALL NEILSON SARAH WELLINGS						NO			213-22-2811			HOSPITAL RECORD 900 SETON DR., CUMBERLAND, MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																									
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u>																																			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>NEPHROSCLEROSIS</u>																																			
DUE TO, OR AS A CONSEQUENCE OF (c) _____																																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____																																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>68</u> , to <u>12-28</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-28</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.																																			
22b. SIGNATURE <u>Michael Glick</u> DEGREE <u>MD</u> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED <u>12-28-68</u>																									
22d. PHYSICIAN'S NAME (Type) <u>MICHAEL GLICK, M. D.</u>										22e. ADDRESS <u>SETON DR., CUMBERLAND, MD. 21502</u>																									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			24 FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																	
Burial			1/1/1969			Laurel Hill Cemetery			Moscow A. Md			EICHORN FUNERAL HOME 8 E. MAIN ST., FORT COCKERMAN			JAN 2 1969			Charles Judge																	

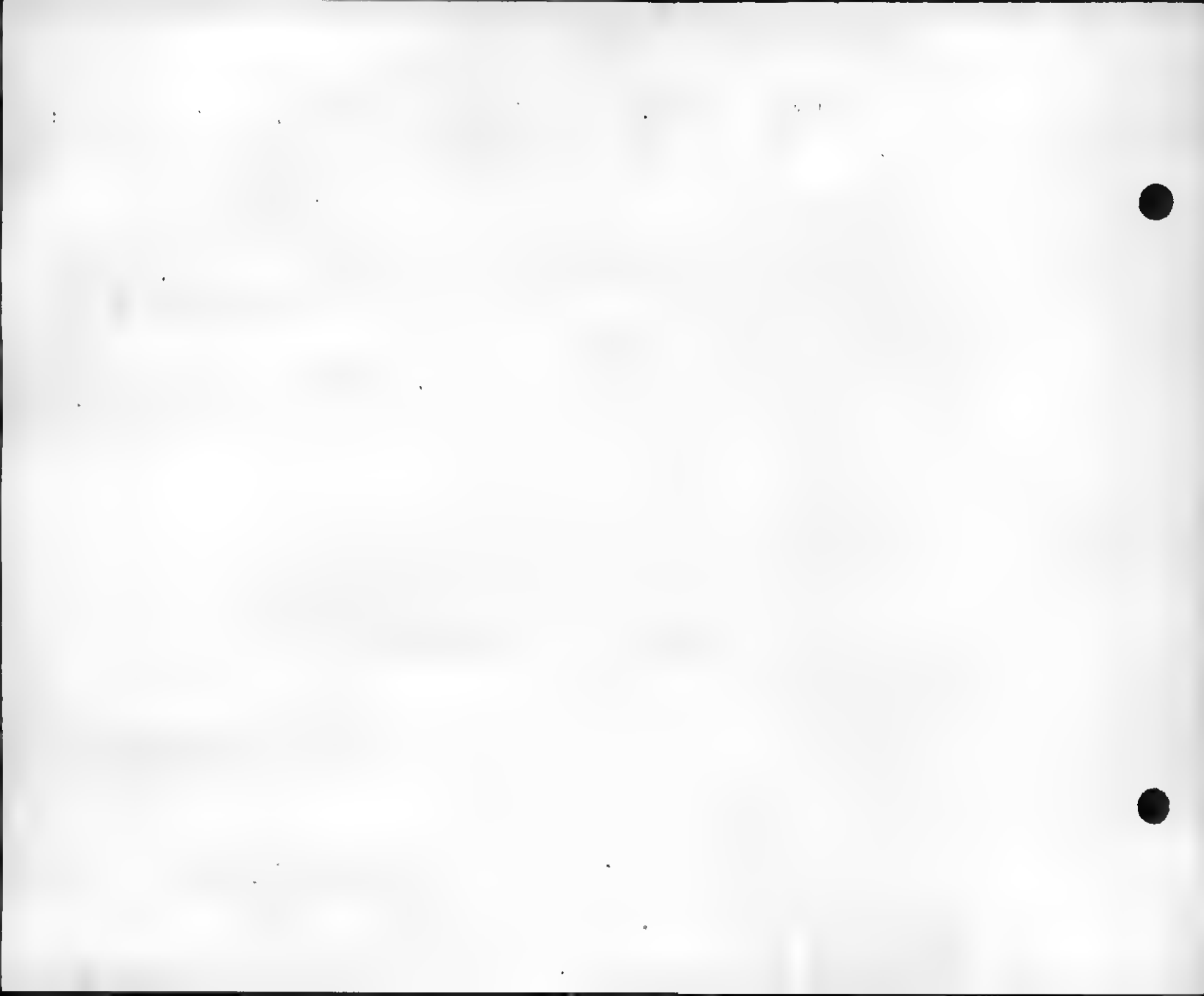


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
JOHN			W. NELSON			Month 12 Day 26 Year 68			6:40 AM				
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 IF UNDER YEAR		7 IF UNDER 24 HRS		
MALE		WHITE		7-3-89			79 YRS		MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			Md	
MARYLAND			USA						ALLEGANY				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
CUMBERLAND			SACRED HEART HOSPITAL			BARBER			BARBER				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER	
MARYLAND			ALLEGANY			CUMBERLAND						COLUMBIA ST. 434 COLUMBIA AVE	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last										
WILLIAM NELSON			MARGARET KELLY										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT			Address				
YES			214-32-3384			PTS. HOSP CHART SACRED HEART HOSPITAL			900 SETON DRIVE CUMBERLAND, MD. 21502				
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u>											<u>1/2 hour</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>coronary sclerosis</u>											<u>3 months</u>		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u>											<u>2 years</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>none</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f LOCATION Street or R.F.D. No City or Town County State							
22a I certify that (I) (this hospital) attended the deceased from <u>11-6-68</u> , to <u>12-26-68</u> , that (I) (we) last saw the deceased alive on <u>12-25-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <u>L. Brings</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED <u>12-26-68</u>				
22d PHYSICIAN'S NAME (Type) <u>LEWIS BRINGS, M.D.</u>						22e ADDRESS <u>57 GREENE ST. CUMBERLAND, MD. 21502</u>							
23a BURIAL CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
<u>Burial</u>			<u>12/28/1968</u>			<u>St. Patrick's Cath Cemetery</u>			<u>Cumberland Alleg Md</u>				
24 FUNERAL DIRECTOR <u>John Hafer</u>			ADDRESS <u>230 BALTO AVE. CUMBERLAND, MD. 21502</u>			REC'D BY REGISTRAR <u>DEC 30 1968</u>			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and infant remains within 72 hours after death.

16754		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				16767	
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH	
REGINALD			JOSEPH	O'CONNOR	12	Month 14 Day 68 Year	2b. HOUR 12:06 PM
3 SEX		4. RACE		5 DATE OF BIRTH		6. AGE (In years lost birthday)	
MALE		WHITE		9-6-96		72 YRS.	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MARYLAND		US OF A				ALLEGANY CO. Md.	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		SACRED HEART HOSPITAL		RETIRED FROM E.L. WALSH		TRUCK DRIVER	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		ALLEGANY		MT. SAVAGE		13e. STREET AND NUMBER	
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME	
JOHN			O'CONNOR	SHAFER	NORA.	E.	O'CONNOR
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.		17 INFORMANT		
YES			218-16-4882		SACRED HEART HOSPITAL HOSPITAL RECORDS 900 SETON DRIVE.. CUMB., MD.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE							2 WEEKS
4120 DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC AND HYPERTENSIVE CVD							2 YEARS
Condit ions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
4431							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21a. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased 88		12-2		1968		to 12-14	
saw the deceased alive on		19		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED		22d. ADDRESS			
R. W. BALLIN, M.D.		12-14-68		62 GREENE ST., CUMBERLAND, MD.			
22a PHYSICIAN'S NAME (Type)		22b. ADDRESS		22c. DATE SIGNED			
R. W. BALLIN, M.D.		62 GREENE ST., CUMBERLAND, MD.		12-14-68			
23a BURIAL, CREMATION (See back)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
BURIAL		12-16-1968		ST. PATRICKS		MT. SAVAGE ALLEG. M.D.	
24. FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		25c DATE	
Joseph K. Scurt, Frostburg, Md.		DEC 18 1968		Charles Judge			

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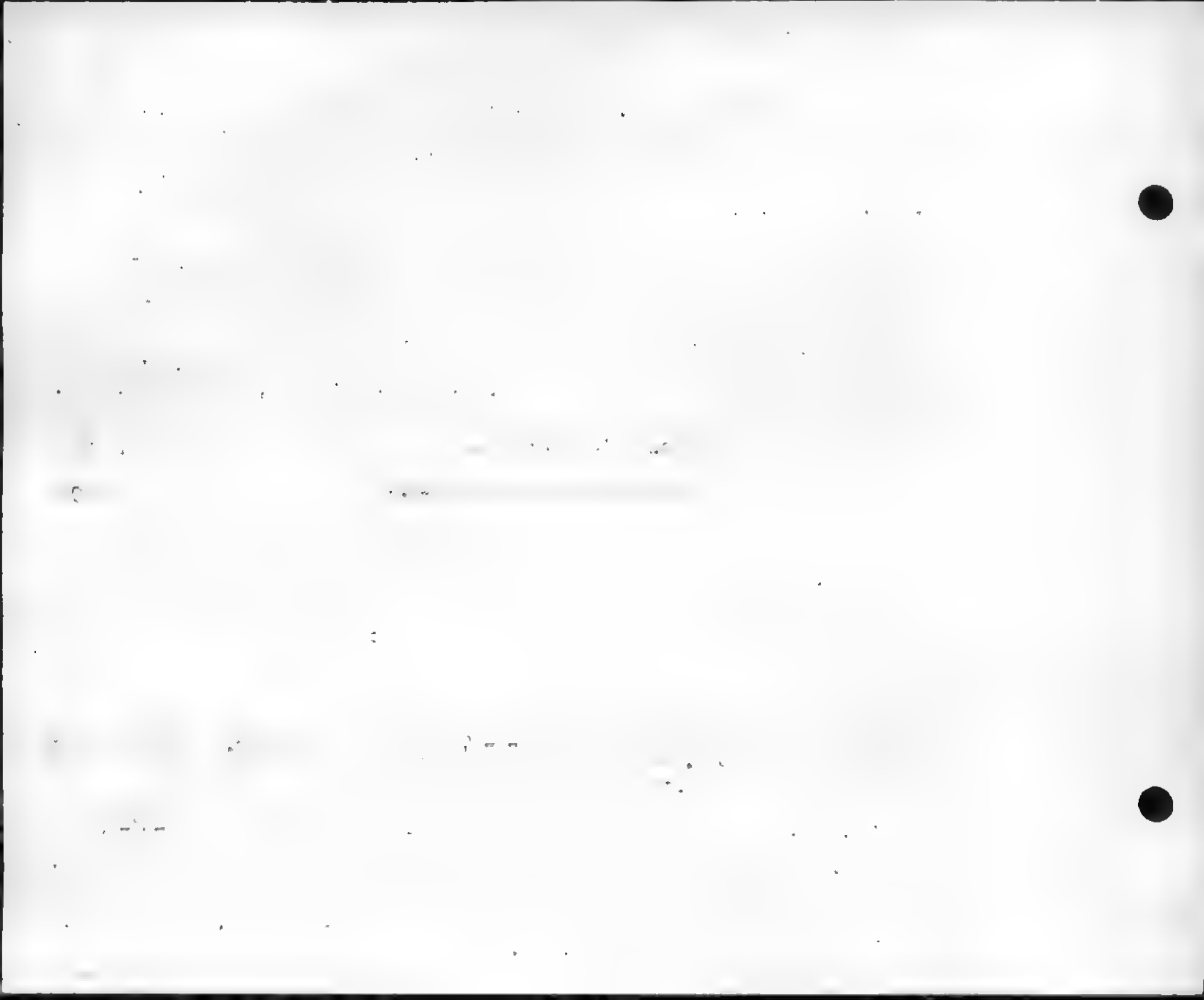
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-7-68

16755										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16768																																							
1 DECEASED-NAME (Type or print)										First Middle Last										2a DATE OF DEATH										2b HOUR P M																													
Maggie										M. Orndorff										Dec.										Month 24 Day 1968- 5:50 M																													
3 SEX					4 RACE					5 DATE OF BIRTH										6 AGE (In years last birthday)					IF UNDER 1 YEAR					IF UNDER 24 HRS																													
Female					White					April 12, 1890										78-78 YRS					MONTHS					DAYS																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
W. Va.										USA																				Allegany Md.																													
10 CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b KIND OF BUSINESS OR INDUSTRY																													
Cumberland										Memorial Hospital										Housewife										Own Home																													
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b COUNTY										13c CITY OR TOWN										13d INSIDE CITY LIM TSP										13e STREET AND NUMBER																			
Md.										Allegany										Cumberland										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										134 Potomac St.																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17 INFORMANT										Address									
John R. Donaldson										Effie Mercer										no																				Mrs. Elizabeth Malone, Cumberland, Md.										Daughter									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART 1. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
174X										DUE TO, OR AS A CONSEQUENCE OF										Metastatic Carcinoma										1966																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)										AdenoCarcinoma of the Breast										1959																													
										(c)																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										12X										Arteriosclerotic Cardiovascular Disease																																							
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																																							
										HOUR A.M. Month Day Year P.M. 19																																																	
21d INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)										21f LOCATION										City or Town										County										State									
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>																				Street or RFD. No																																							
22a. I certify that (I) (this hospital) attended the deceased from 6-4-57, 19, to Dec., 19 68, that (I) (we) lost saw the deceased alive on Dec. 24, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																																																											
22b. SIGNATURE										DEGREE										ATTENDING PHYS.										MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c DATE SIGNED																			
																																								12-31-68																			
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
Dr. G. Overton Himmelwright										133 Virginia Ave., Cumberland, Md.																																																	
23a BURIAL CREMATION, REMOVAL (Specify)										23b DATE										23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or Town)										(County)										(State)									
Burial										Dec. 28, 1968										Greenmount Cemetery										Cumberland, Md.										Allegany, Md.																			
24 FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
James F. Scarpelli, Cumberland, Md.																				DATE JAN 6 1969										Charles Judge																													

MEDICAL CERTIFICATION



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

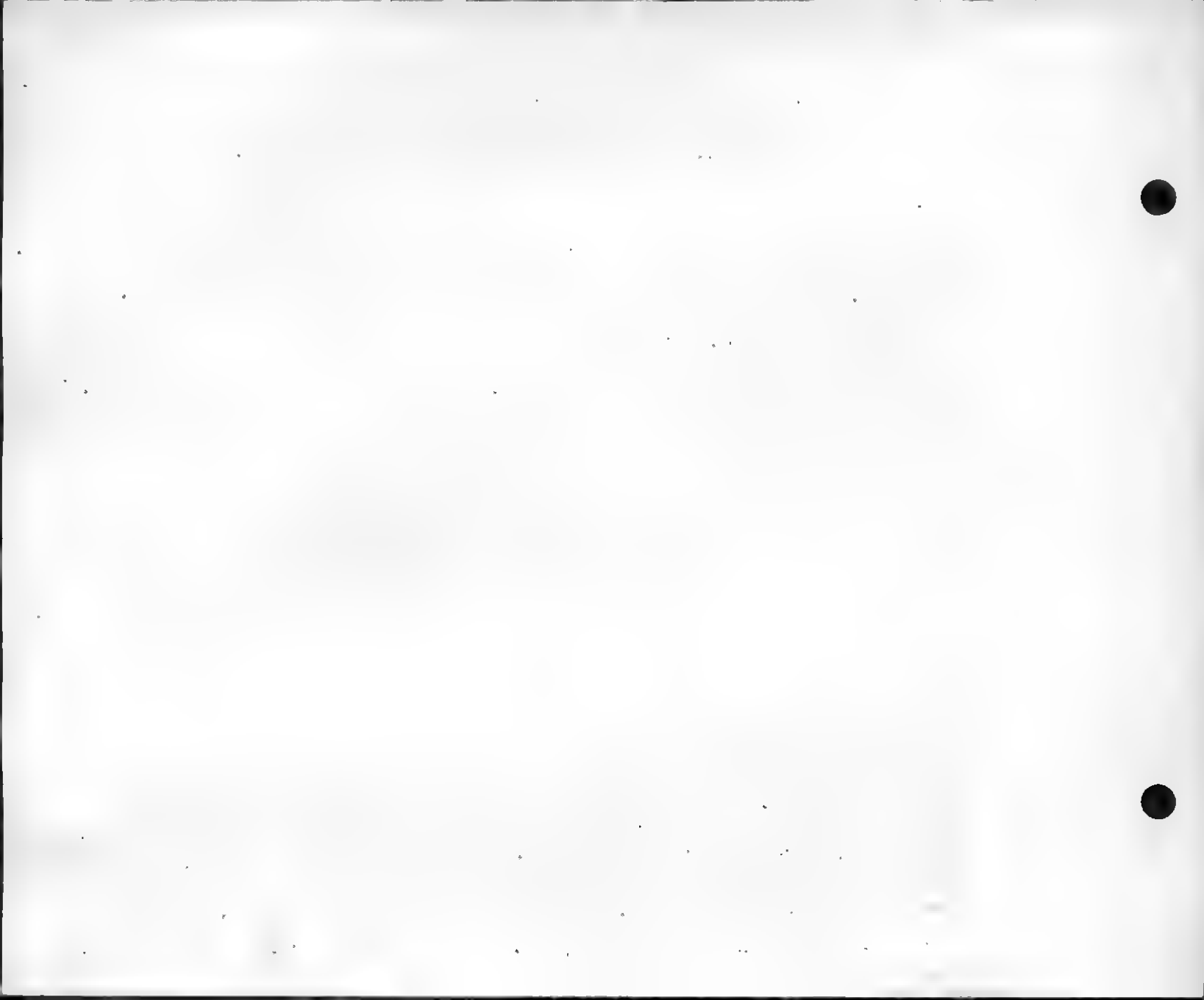
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16756

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16769

1 DECEASED-NAME (Type or Print) <b>WOODROW W. OSBOURNE</b>			2a DATE KNOWN OF ESTI. DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Dec. 26 1968			2b HOUR <input type="checkbox"/> 2:30 PM					
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>May 30, 1915</b>	6 AGE (in years last birthday) <b>53</b> YRS.	7 UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	8 UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Dec. 26 1968			2d HOUR <b>3P M</b>		
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Allegany</b>					
10 CITY OR TOWN OF DEATH <b>Cumberland</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>23 Virginia Ave.</b>			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Maintenance</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Postal Dept.</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			13b COUNTY <b>Allegany</b>			13c CITY OR TOWN <b>Cumberland</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME <b>Milton E. Osbourne</b>			15 MOTHER'S MAIDEN NAME <b>Florence S. Wharton</b>			13e STREET AND NUMBER <b>23 Virginia Ave.</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>			16b SOCIAL SECURITY NO <b>War II</b>			17 INFORMANT <b>Mts. Agatha Osbourne, Cumberland, Md.-Wife</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO, OR AS A CONSEQUENCE OF <b>CORONARY THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CORONARY SCLEROSIS</b> (c) <b>----</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>----</b>											
19a DATE OF OPERATION <b>----</b>				19b CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>----</b>				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> <b>9</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>----</b>					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>----</b>			21f LOCATION Street or R.F.D. No <input type="checkbox"/> City or Town <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>			EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <b>December 26, 1968</b>		
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b DATE <b>Dec. 29, 1968</b>			23c NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>			23d LOCATION (City or Town) (County) (State) <b>Cumberland, Md. Allegany</b>		
24 FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						25a REC'D BY REGISTRAR DATE <b>JAN 3 1969</b>			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16757

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16770

1 DECEASED NAME (Type or print) First Middle Last <b>BURLEY NMI PENNINGTON</b>			2a DATE OF DEATH Month 12 Day 24 Year 68		2b HOUR P 11:59
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>03-08-92</b>		6 AGE (In years last birthday) <b>76</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>ALLEGANY COUNTY,</b> Md					
10 CITY OR TOWN OF DEATH <b>CUMBERLAND,</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>COOK</b>	
12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>		13b COUNTY <b>ALLEGANY</b>	13c CITY OR TOWN <b>CUMBERLAND</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>225 BALTIMORE STREET</b>
14. FATHER'S NAME First Middle Last <b>NATHANIEL J. BENNINGTON</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>(REDACTED) LUCRETTA (Flannigan) PENNINGTON</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b SOCIAL SECURITY NO <b>215-20-6160</b>		17 INFORMANT Address <b>SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>LEFT VENTRICULAR FAILURE</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b> <b>3 YEARS</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from <b>12 - 16, 1968</b> , to <b>12 - 24 1968</b> , that (I) (we) last saw the deceased alive on <b>12 - 24 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>R. W. Ballin</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <b>12-25-68</b>	
22d PHYSICIAN'S NAME (Type) <b>R.W. BALLIN, M.D.</b>		22e ADDRESS <b>62 GREENE ST., CUMBERLAND, MD. 21502</b>			
23a BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		23b DATE <b>12/31/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove</b>	
23d LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md</b>					
24. FUNERAL DIRECTOR <i>Stein Funeral Home</i>		ADDRESS <b>STEIN FUNERAL HOME, 117 FREDERICK ST., CITY</b>		25a REC'D BY REGISTRAR <b>DEC 31 1968</b>	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

[illegible]

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151

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16758

CERTIFICATE OF DEATH

16771

1 DECEASED NAME (Type or print) <b>LOUISE</b>		First <b>M.</b>	Middle	Last <b>PLUMMER</b>	2a. DATE OF DEATH Month <b>12</b> Day <b>25</b> Year <b>68</b>		2b. HOUR <b>7:55A</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>10-19-15</b>		6 AGE (In years birthday) <b>53</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during last 12 months) <b>GEN. MGR. TEXTILE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TEXTILES CO.</b>		
13a. USUAL RESIDENCE (Where deceased lived if institution admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>FROSTBURG</b>		13d. INSIDE CITY, MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1 SUSANNA ST.</b>
14 FATHER'S NAME First <b>WILLIAM</b> Middle <b>S.</b> Last <b>PLUMMER</b>		15 MOTHER'S MAIDEN NAME First <b>ANNE</b> Middle <b>MAE</b> Last <b>WAGONER</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <input checked="" type="checkbox"/> unknown <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>217-10-4162</b>		17 INFORMANT <b>HOSPITAL RECORD, 900 SETON DR., CUMB., MD.</b>				
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>stroke</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>hypertension</b> (b) <b>arteriosclerosis, old white</b> (c) <b>arteriosclerosis, old white</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>1 year</b> <b>2 years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>334.</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory, office building etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>12/11/68</b> to <b>12-25-68</b> , that (I) (we) last saw the deceased alive on <b>12-24-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>L. Brings</b>		DEGREE <b>MD.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12-25-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS M.D.</b>		22e. ADDRESS <b>57 GREENE ST., CUMBERLAND, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>DEC. 28, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F.B.G. MEMORIAL HOSPITAL</b>		23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>		
24 FUNERAL DIRECTOR <b>DURST FUNERAL HOME</b>		ADDRESS <b>FROSTBURG, MD. 21532</b>		25a. RECEIVED BY REGISTRAR DATE <b>DEC 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Section 1, Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and on any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16772									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										16759									
1 DECEASED NAME (Type or Print)			First		Middle		Last		20. DATE KNOWN OF ESTI-DEATH MATED			2b HOUR							
Maurice Winfield Rice									Dec. 26 19 68			8P M							
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years for birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR					
Male		White		Dec. 6, 1892		76 YRS						Month Dec. Day 26 Year 19 68		8P M					
7a BIRTHPLACE (State or foreign country)			7b CIT ZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> D. VORCED <input type="checkbox"/>			9 COUNTY OF DEATH					Md.					
Maryland			USA						Allegany										
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland				D.O.A. Memorial H.				Retired Boiler Maker				Railroad							
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			3d. INSIDE CITY IN 15?			13e. STREET AND NUMBER							
Md.			Allegany			Cumberland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			15 Laing Ave.							
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO				
Scott Rice					Unknown					no									
17 INFORMANT										ADDRESS									
Mr. Quentin Rice, Cumberland, Md.-Son																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY:												SUDDEN							
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																			
(b) CORONARY SCLEROSIS																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
4201																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?											
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
				19															
21d. N. LRY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No				City or Town		County		State			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>																			
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
22a. I certify that I took charge of the remains described above, held on				Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE				Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				Dr. Benedict Skitarelic MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				December 26, 1968							
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Rt. 9, Cumberland, Md.							
								ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				Dec. 29, 1968				Sunset Memorial Park				Cumberland, Allegany, Md.							
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
James F. Scarpelli				Cumberland, Md.				JAN 3 1969				J Charles Judge							

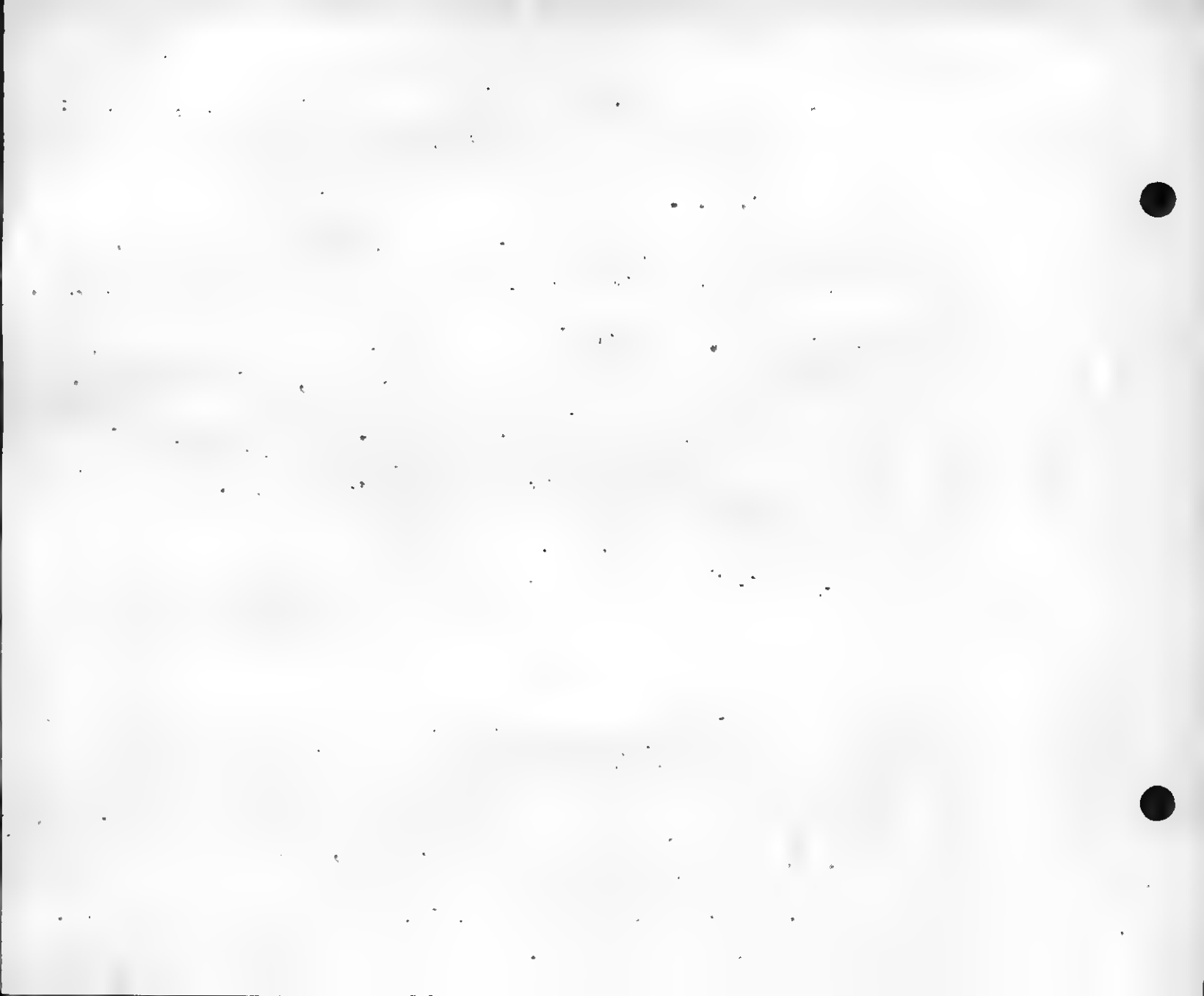


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16760  
16773  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>GERALD C. RILEY</b>		2a. DATE OF DEATH <b>DECEMBER 28, 1968</b>		2b. HOUR <b>4:35 PM</b>	
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>1-7-1901</b>		6. AGE <b>67</b> YRS	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>ALLEGANY</b>		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during month of death, if even if retired) <b>RETIRED MACHINIST</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. STREET AND NUMBER <b>1101 LAFAYETTE AVE.</b>	
14. FATHER'S NAME First <b>JAMES</b> Middle <b>C.</b> Last <b>RILEY</b>		15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (cardiogenic stroke)</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic cerebrovascular disease</b> PART 2 - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cerebrovascular disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (At home farm, street factory, office building etc.)		21c. LOCATION Street or R.F.D. No City or Town County State <b>Cumberland Allegany Md</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/27/68</b> , 19 <b>68</b> , to <b>12/28/68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/28/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>R. J. Williams</b>		DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/29/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>R. J. WILLIAMS</b>		22e. ADDRESS <b>CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 31, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	
23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>		23e. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>			
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR <b>JAN 2 1969</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the Health Department's copy. 5 may be retained for your files.

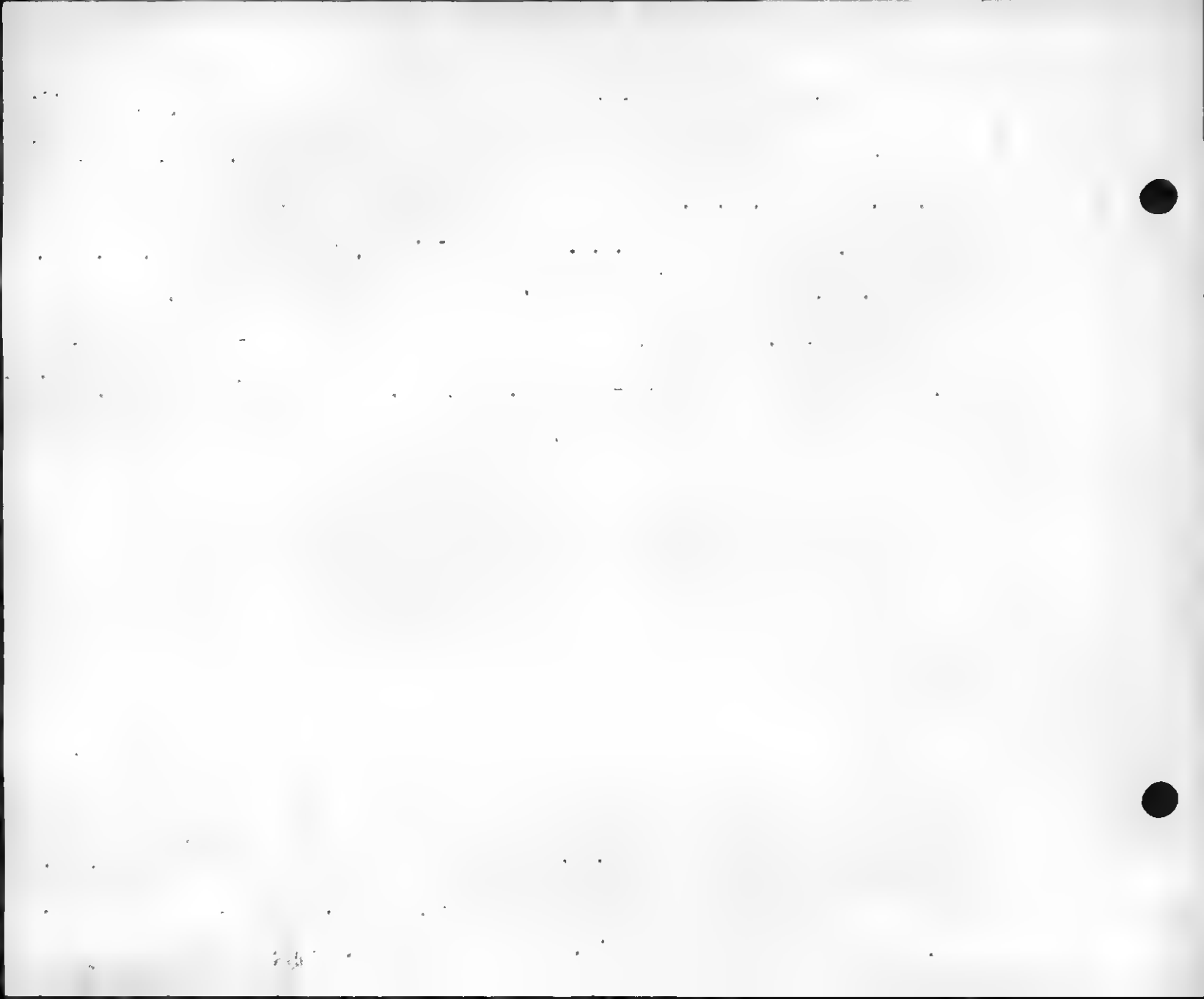
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16761

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16774

1. DECEASED-NAME (Type or Print) <b>Stanley Gerant Robertson</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>Dec.</b> Day <b>28,</b> Year <b>1968</b>			2b. HOUR <b>10:10</b>		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>June 19, 1900</b>	6 AGE (In years last birthday) <b>68</b> YRS	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS HOURS <b></b> MIN <b></b>	2c. DATE PRONOUNCED DEAD Month <b>Dec.</b> Day <b>28,</b> Year <b>1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		7b. C.T.ZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Allegany</b> Md.		
10 CITY OR TOWN OF DEATH <b>Cumberland,</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>D.O.A. Memorial Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Ret. Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>W. Md. Rwy.</b>		
13a. USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>W. Va.</b>		13b. COUNTY <b>Mineral</b>		13c. CITY OR TOWN <b>Ridgeley,</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>39 Blocker St.</b>
14 FATHER'S NAME First <b>Charles N. Robertson,</b> Middle <b></b> Last <b></b>			15 MOTHER'S MAIDEN NAME First <b>Viola</b> Middle <b>--</b> Last <b>Northcraft</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOC.A. SECURITY NO <b>705-10-7709</b>		17 INFORMANT <b>Mt. Lowell S. Robertson</b> ADDRESS <b>Ridgeley, W. VA.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>CORONARY SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>---</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b></b>								
19a. DATE OF OPERATION <b></b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b></b>		21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. <b></b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b></b>				
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b></b>		21f. LOCATION Street or R.F.D. No <b></b> City or Town <b></b> County <b></b> State <b></b>				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M. D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/28/68</b> <b>Rt. 9</b> <b>Cumberland, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/31/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenridge Cemetery,</b>		23d. LOCATION (City or Town) (County) (State) <b>nr. Oldtown, Allegany Md.</b>		
24 FUNERAL DIRECTOR <b>H. Wayne George</b> ADDRESS <b>Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 2 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

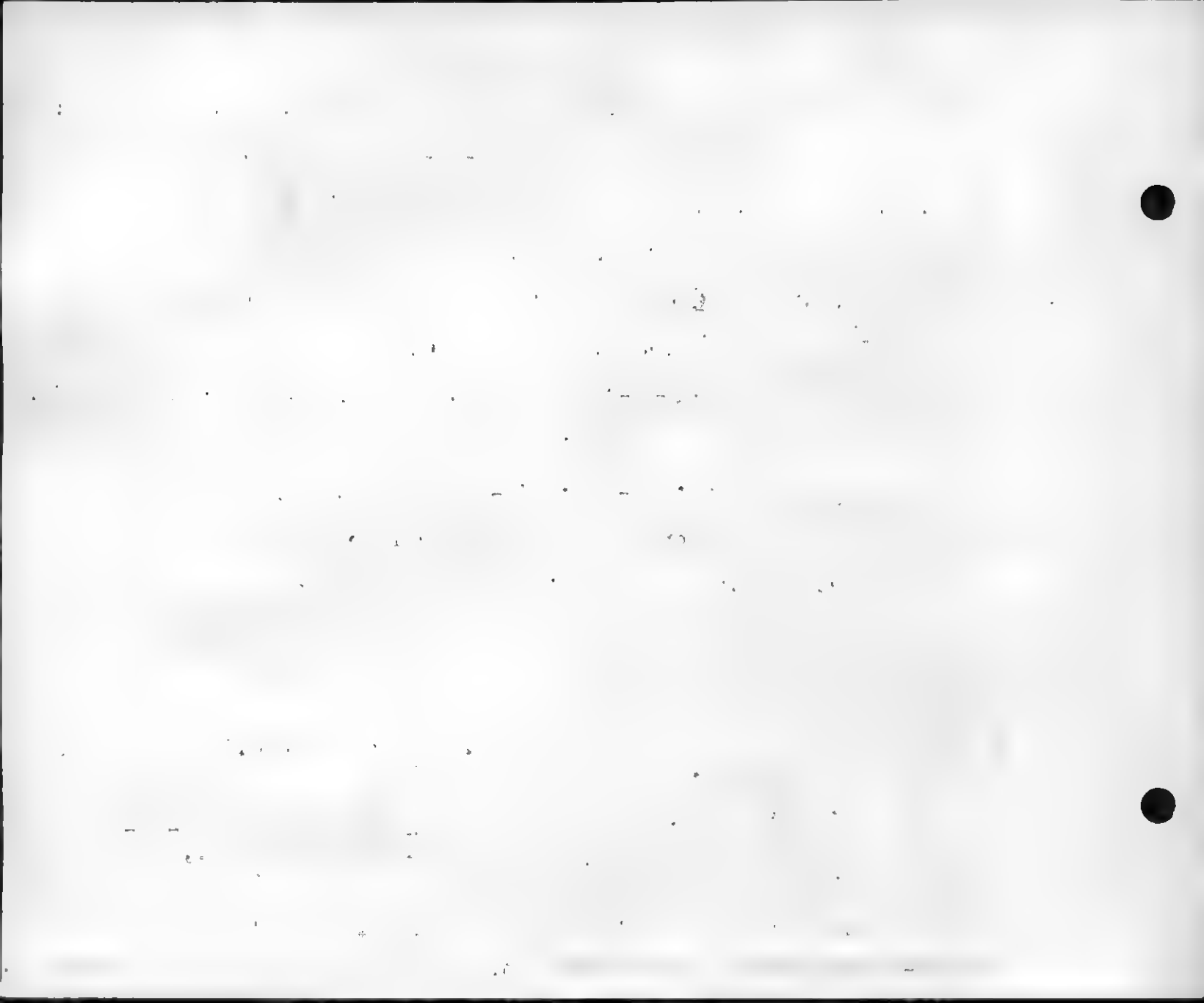
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16762

CERTIFICATE OF DEATH

16775

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
PERSIS		L.		ROBY	DECEMBER 18, 1968		8:35 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS
FEMALE	WHITE		9-16-1897		71 YRS.	MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
W.VA.	U. S.A.				ALLEGANY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of year, or if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		MEMORIAL HOSPITAL		HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND		ALLEGANY		CUMBERLAND				403 LINDEN ST.
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
JOHN				SHROUT	LUCY			HARTMAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		215-50-0483		MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septemia								4 weeks
DUE TO, OR AS A CONSEQUENCE OF (b) Diffuse-multiple-systemic myocotic abscesses								
DUE TO, OR AS A CONSEQUENCE OF (c) Miliary tuberculosis - Active								
Secondary to Acute Viral Infection								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
Arteriosclerotic Cardio-Vascular Disease								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21a. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Nov. 18, 1968, to Dec. 18, 1968, that (I) (we) last saw the deceased alive on Dec. 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b. SIGNATURE						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-20-68
22d. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT						22e. ADDRESS 133 Virginia Ave., CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		12/21/68		Sunset Memorial Park		Cumberland Allegany Maryland		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service Cumberland, Md						DEC 23 1968		Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

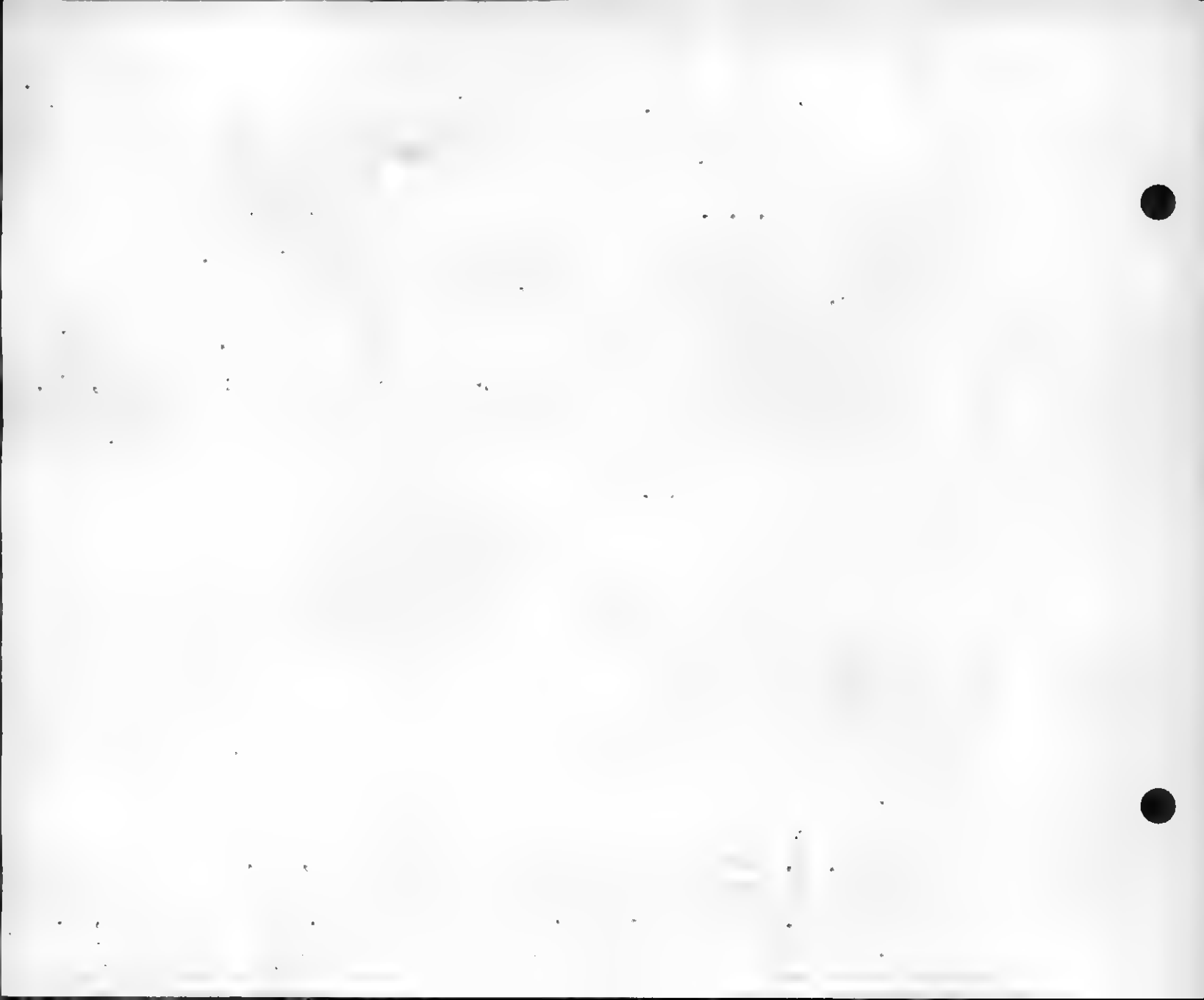
CERTIFICATE OF DEATH

16763

16776

1. DECEASED-NAME (Type or print)		First <b>MARY</b>		Middle <b>M.</b>		Last <b>ROSS</b>		2c. DATE OF DEATH <b>12</b> <b>23</b> <b>68</b>				2b. HOUR <b>10:40</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>9-27-1894</b>				6. AGE (In years) <b>74</b> <b>1/8</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>				Md			
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Maintenance Dept.</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Tire</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <b>WEST VA.</b>		13b. COUNTY <b>1b</b>		13c. CITY OR TOWN <b>RIDGELEY</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
14. FATHER'S NAME		First <b>JOHN</b>		Middle		Last <b>WAXLER</b>		15. MOTHER'S MAIDEN NAME		First <b>MARY</b>		Middle <b>S.</b> Last <b>LEASE</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL</b>				Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Brain aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>57</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>72</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 22, 1950</b> to <b>1/15, 1968</b> , that (I) (we) last saw the deceased alive on <b>1/15, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>DR. B. SCHINDLER</b>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>1/14/68</b>							
22d. PHYSICIAN'S NAME (Type) <b>DR. B. SCHINDLER</b>		22e. ADDRESS <b>CUMBERLAND, MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Dec. 26, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>				23d. LOCATION (City or Town)		(County)		(State) <b>Cumberland, Allegany, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

MEDICAL CERTIFICATION



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

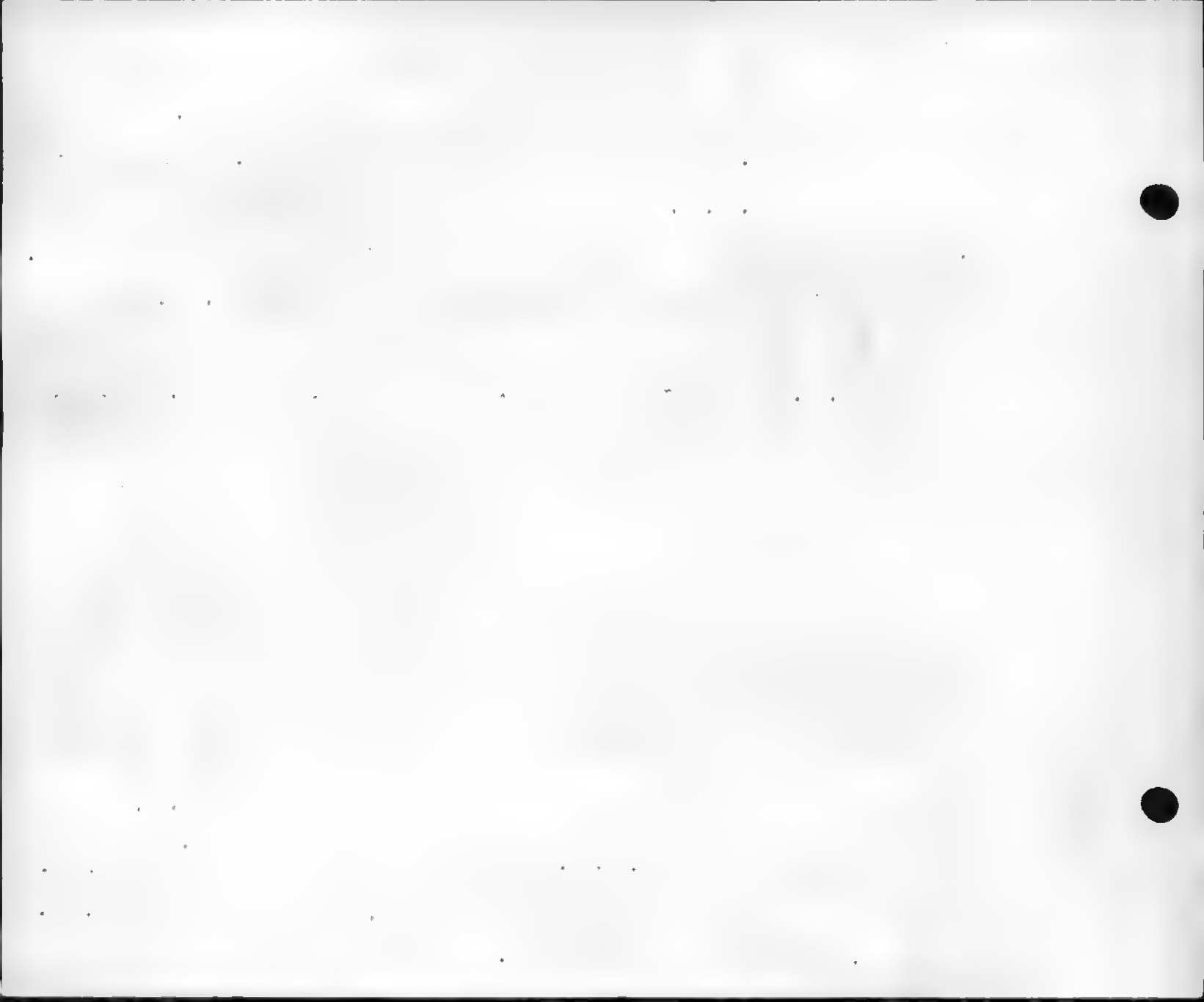
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16762

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

16777

1 DECEASED NAME (Type or Print) <b>John Thomas Royer</b>			2a DATE KNOWN OF DEATH Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> <b>Dec. 2, 1968</b>			2b HOUR OF DEATH <b>7:00 PM</b>		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>Apr. 27, 1910</b>	6 AGE (In years last birthday) <b>58 YRS</b>	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month <b>Dec.</b> Day <b>4</b> Year <b>1968</b>		
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Allegany</b>		
10. CITY OR TOWN OF DEATH <b>Rt. # 3 Cumberland</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Eastman Road</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Orchard Wkr.</b>
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b COUNTY <b>Allegany</b>	13c CITY OR TOWN <b>Cumberland</b>	3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <b>Eastman Rd. Rt. # 3</b>		
14. FATHER'S NAME First <b>John</b> Middle <b>Thomas</b> Last <b>Royer</b>			15 MOTHER'S MAIDEN NAME First <b>Effie</b> Middle <b>--</b> Last <b>Cowgill</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16b SOCIAL SECURITY NO. (If yes give year or dates of service) <b>U. S. # 2 234-24-4045</b>		17. INFORMANT <b>Mrs. Sylvia Wharton</b> ADDRESS <b>447 Seymour St. Cumb. Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Acute Pulmonary Edema</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac Hypertrophy</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial Infarctions</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>--</b> <b>Old</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Coronary Sclerosis; Pulmonary Emphysema</b>								
19a. DATE OF OPERATION <b>7-1-1</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Coronary Sclerosis; Pulmonary Emphysema</b>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			Dec. 4 1968		
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M. D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <b>Rt. # 9</b>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <b>Cumberland, Md.</b>		
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>12/6/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Camp Hill Cemetery</b>		23d LOCATION (City or Town) <b>Paw Paw</b>		(County) <b>Morgan, W. Va.</b>	(State)
24 FUNERAL DIRECTOR <b>H. Wayne George</b>			ADDRESS <b>Cumberland, Md.</b>			25a REC'D BY REGISTRAR DATE <b>DEC 9 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed from the certificate. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16765

CERTIFICATE OF DEATH

16778

1. DECEASED NAME (Type or print) <b>DONALD</b>			First Middle Last <b>B. SCHARF</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>6</b> Year <b>68</b>			2b. HOUR <b>3:45</b> PM		
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>9-1-1919</b>			6. AGE (in years last birthday) <b>50</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ALLEGANY</b> Md.		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CARPENTER</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>ALLEGANY</b>			13c. CITY OR TOWN <b>CUMB.</b>			13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>214 PULASKI ST.</b>			14. FATHER'S NAME First Middle Last <b>DONALD R. SCHARF</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>(BARRETT) FLORENCE BARRETT</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WW II 214-07-2322</b>			17. INFORMANT <b>MEMORIAL HOSPITAL</b>			Address <b>CUMBERLAND, MD.</b>		
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma Lung</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiac Failure</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 mon</b> <b>3 mon</b> <b>10 days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 10, 1968 to 12/6/68</b> , that (I) (we) last saw the deceased alive on <b>12/5/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Clay E. Durrett</b>			DEGREE <b>M.D.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>12/6/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>CLAY E. DURRETT, M.D.</b>			22e. ADDRESS <b>236 VIRGINIA AVE., CUMB., MD.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>12/8/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>		
24. FUNERAL DIRECTOR <b>Silcox-Merritt Funeral Service</b>						ADDRESS <b>Cumberland, Md</b>			25a. REC'D BY REGISTRAR <b>DEC 9 1968</b>		
									25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



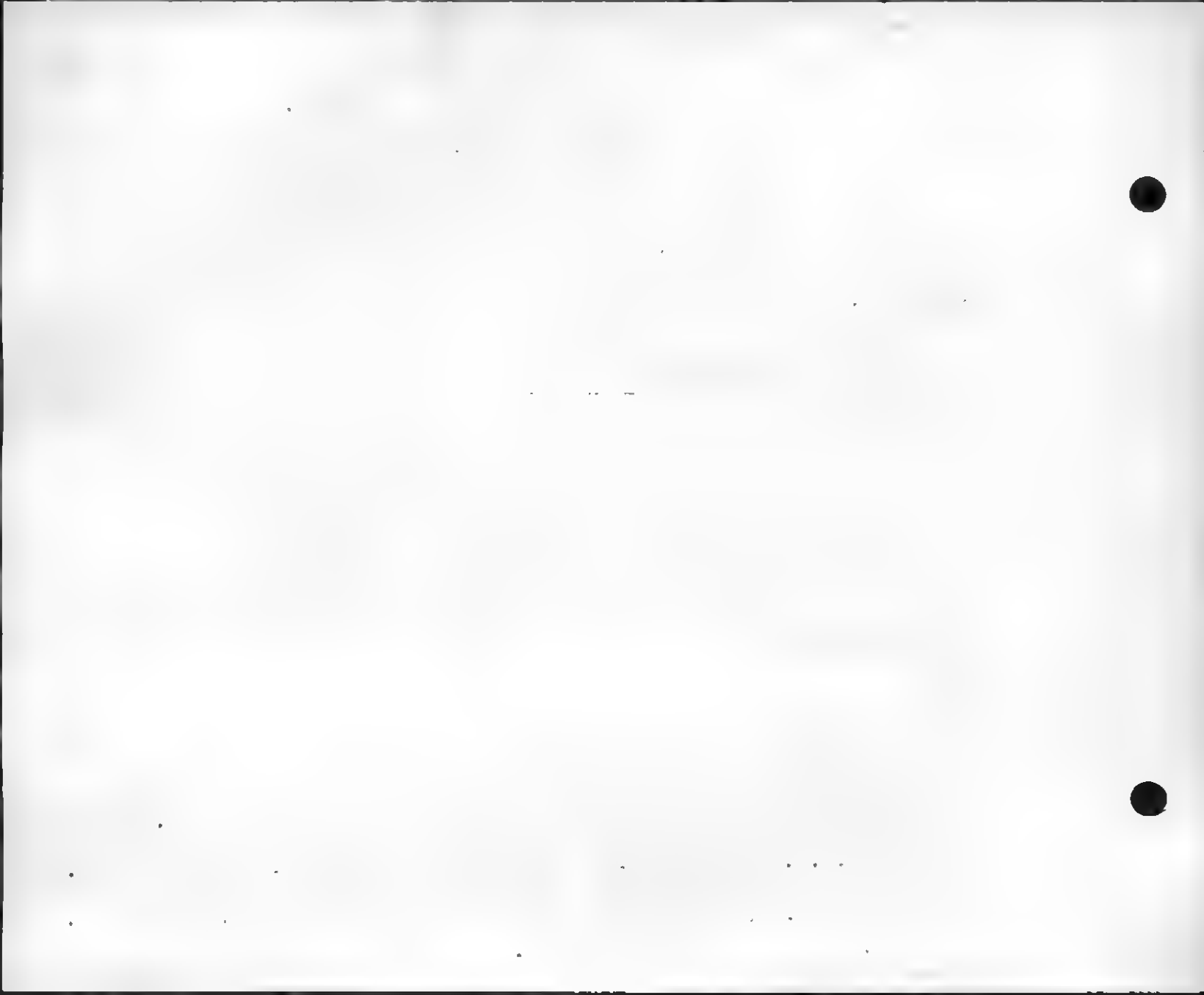
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VR A15  
304 REV 11-60

<div style="display: flex; justify-content: space-between;"> <span>16766</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>CERTIFICATE OF DEATH</span> <span>16779</span> </div>																					
1 DECEASED NAME (Type or print) <b>Myrtle</b>			First <b>M</b>			Last <b>Smith</b>			2a. DATE OF DEATH Dec. Month <b>22</b> Day <b>68</b> Year			2b. HOUR <b>950P</b>									
3 SEX <b>Female</b>			4 RACE <b>White</b>			5 DATE OF BIRTH <b>7-16-97</b>			6 AGE (In years last birthday) <b>71</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN								
7a BIRTHPLACE (State or foreign country) <b>Cumberland</b>			7b CIT ZEN OF WHAT COUNTRY? <b>Allegany</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Allegany</b>												
10 CITY OR TOWN OF DEATH <b>Cumberland</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cumberl and Nursing Center</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR IND. STRY <b>Onw Home</b>												
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>601- Md.</b>			13b. COUNTY <b>Allegany</b>			13c. CITY OR TOWN <b>Cumberland</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>601 1/2 Hilltop Drive</b>										
14 FATHER'S NAME <b>John</b>			First <b>O Neal</b>			Last <b>Mary Ellen</b>			Middle <b>Mc Donaald</b>												
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>214-05-7210-A</b>			17 INFORMANT <b>Marie Lowery Daughter</b>												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1541</b> <b>Concussion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 years</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>154X</b>																					
19a. DATE OF OPERATION <b>Aug. 1967</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Brain tumor</b>			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?												
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)															
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State															
22a. I certify that (I) (th s hospital) attended the deceased from <b>August 1967</b> to <b>22 Dec. 1968</b> , that (I) (we) last saw the deceased alive on <b>5-22-68</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour one from the causes stated above. (I) (we) (d d) (did not) view the body after death.																					
22b. SIGNATURE <b>Dr. R.W. Miltenberger</b>												DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>Dec. 30, 1968</b>	
22d PHYSICIAN'S NAME (Type) <b>Dr. R.W. Miltenberger, MD</b>												22e ADDRESS <b>122 S. Centre St., Cumberland, Md.</b>									
23a BURIAL, CREMATION, or other (Specify)			23b DATE <b>Dec. 26, 1968</b>			23c NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>			23d LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>												
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JAN 2 1969</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>											

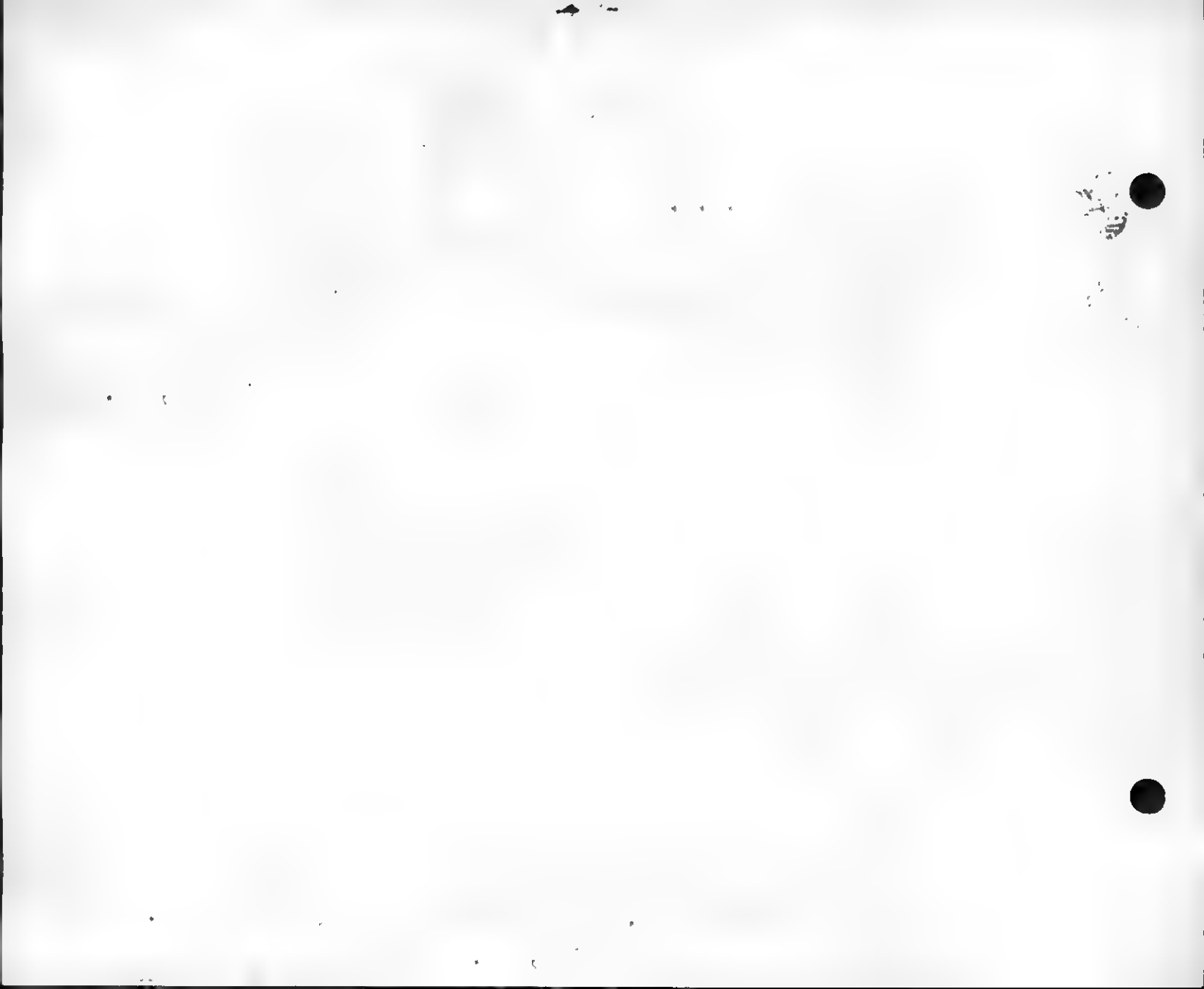
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>16787</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 13 Film 408 1/6/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>16780</div>											
1. DECEASED-NAME (Type or print) <b>Florence Beckley Snelson</b>						2a. DATE OF DEATH Month <b>12</b> Day <b>24</b> Year <b>1968</b>			2b. HOUR M		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>2/21/1888</b>			6. AGE (In years last birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>England</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.					
10. CITY OR TOWN OF DEATH <b>Lonaconing</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Kyle Nurseing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>none</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Md</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Midland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Lonaconing Street 21542</b>		
14. FATHER'S NAME First Middle Last <b>Joseph Beckley</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>no</b>				16b. SOCIAL SECURITY NO.		17. INFORMANT <b>James Snelson</b>			Address <b>Midland, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> <b>411</b> DUE TO, OR AS A CONSEQUENCE OF (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201</b> ) (b) <b>Generalized Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Influenza</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 21</b> , 19 <b>68</b> , to <b>Dec. 24</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>Dec. 21</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>L.R. Miles Jr.</b> DEGREE <b>M.D.</b> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED <b>12.24.68</b>					
22d. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b>						22e. ADDRESS <b>LONA CONING MD 21539</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/27/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. George Cemetery</b>		23d. LOCATION (City or Town) <b>Mt. Savage</b>		(County) <b>A.</b>		(State) <b>Md</b>	
24. FUNERAL DIRECTOR <b>George Eichhorn</b>				ADDRESS <b>Lonaconing, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (or detach) pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
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16768

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16781

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month		12	Day	28	Year	68	2b HOUR	10:30	AM
JOHN		T.		SPRIGGS										
3 SEX	MALE		4 RACE	WHITE		5 DATE OF BIRTH	5-7-01		6 AGE (in years last birthday)	67		7 UNDER 1 YEAR	IF UNDER 24 HRS.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		ALLEGANY Md						
MARYLAND		US OF A												
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY								
CUMBERLAND		SACRED HEART HOSPITAL		RETIRED MAIL CARRIER										
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER						
MARYLAND		ALLEGANY		FLINTSTONE				None						
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last					
WILLIAM				SPRIGGS	??		KATHERINE		SPRIGGS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b SOC AL SECURITY NO		17 INFORMANT		Address								
XX YES		578-12-1843		SACRED HEART HOSP. RECORDS, CUMBERLAND, MD.		800 SETON DRIVE								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART 1. DEATH WAS CAUSED BY														
IMMEDIATE CAUSE (a) <u>Cerebral-vascular accident</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
(b) <u>To infarct basilar disease</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
MEDICAL CERTIFICATION														
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
16 Jan 68		Intestine resection		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (1) (this hospital) attended the deceased from 10 Jan, 1968, to 28 Jan, 1968, that (1) (we) last saw the deceased alive on 28 Jan 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.														
22b. SIGNATURE														
22c. DATE SIGNED														
22d. PHYSICIAN'S NAME (Type) F. W. MILTENBERGER, M.D.														
22e. ADDRESS 201 GRAND AVE., CUMBERLAND, MD.														
23a BURIAL, CREMATION, or other disposition (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)								
Burial		Dec. 31, 1968		Hillcrest Burial Park		Cumberland, Allegany, Md.								
24. FUNERAL DIRECTOR														
James F. Scarpelli, Cumberland, Md.														
25a. REC'D BY REGISTRAR														
25b. REGISTRAR'S SIGNATURE														
DATE JAN 2 1968														

Charles Judge

— KKKK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

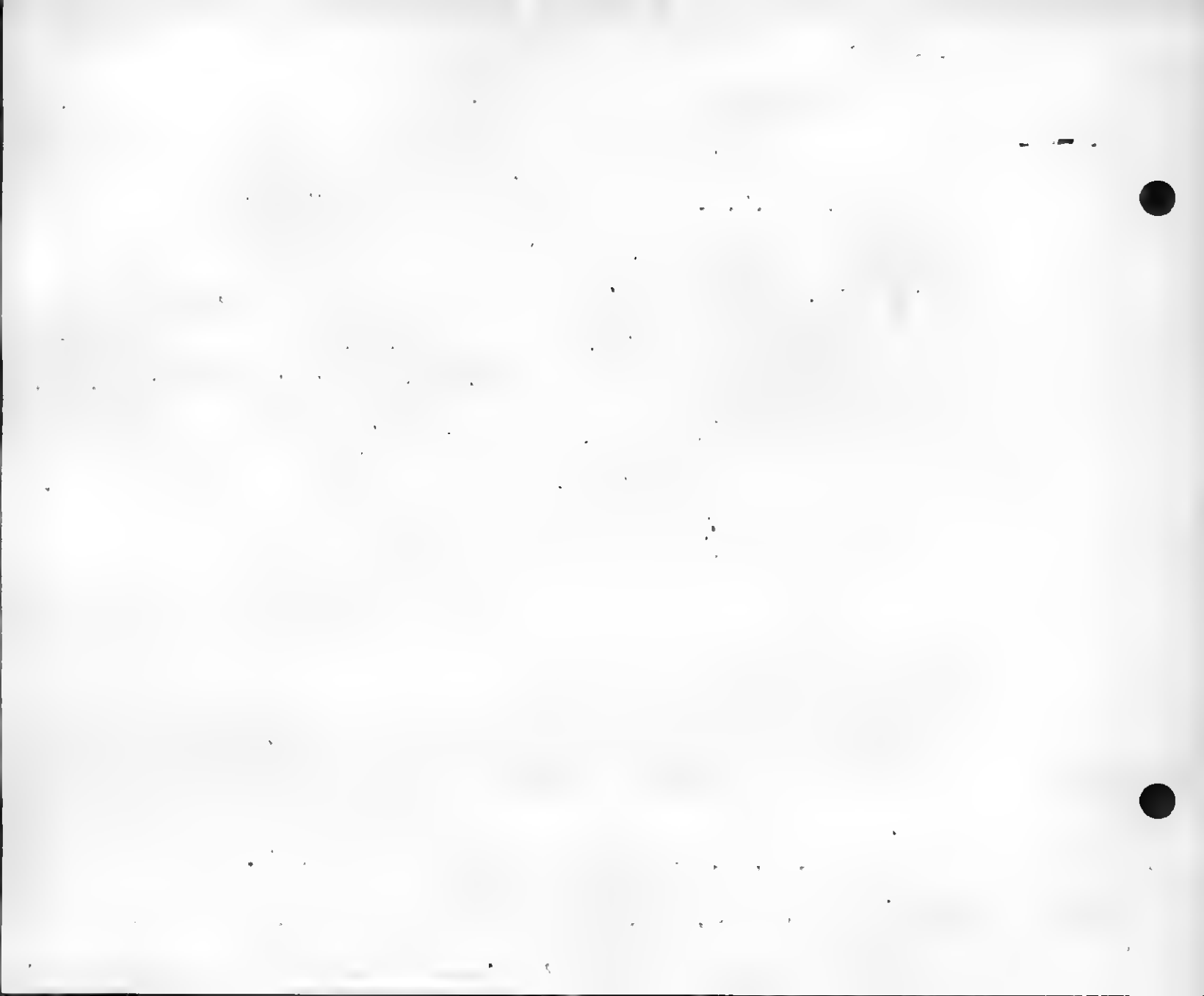
VR A15  
30A REV. 1-69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

16769

16782

1. DECEASED NAME (Type or print) <b>LENNIE M STEELE</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>5</b> Year <b>68</b>			2b. HOUR <b>7:25</b> A.M.	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>4-28-98</b>		6. AGE (In years last birthday) <b>70</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>LONA CONING</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last <b>WILLIAM PIPER</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>JENNIE BILBEE</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal congestive heart failure</b> <b>109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction, antec. coronal &amp; bifurc.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>A.S. cardiovascular disease</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b> <b>Early, July 68</b> <b>10 years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>diabetes mellitus, 11+ years</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>22 July, 1968</b> , to <b>5 Dec., 1968</b> , that (I) <del>(two)</del> last saw the deceased alive on <b>4 Dec.</b> 1968, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <b>(did)</b> (did not) view the body after death.							
22b. SIGNATURE <b>W. A. Van Ormer, M.D.</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5 July 68</b>	
22d. PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>				22e. ADDRESS <b>CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/7/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Steele Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Lonaconing A. Md</b>	
24. FUNERAL DIRECTOR ADDRESS <b>George Eichhorn Lonaconing, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



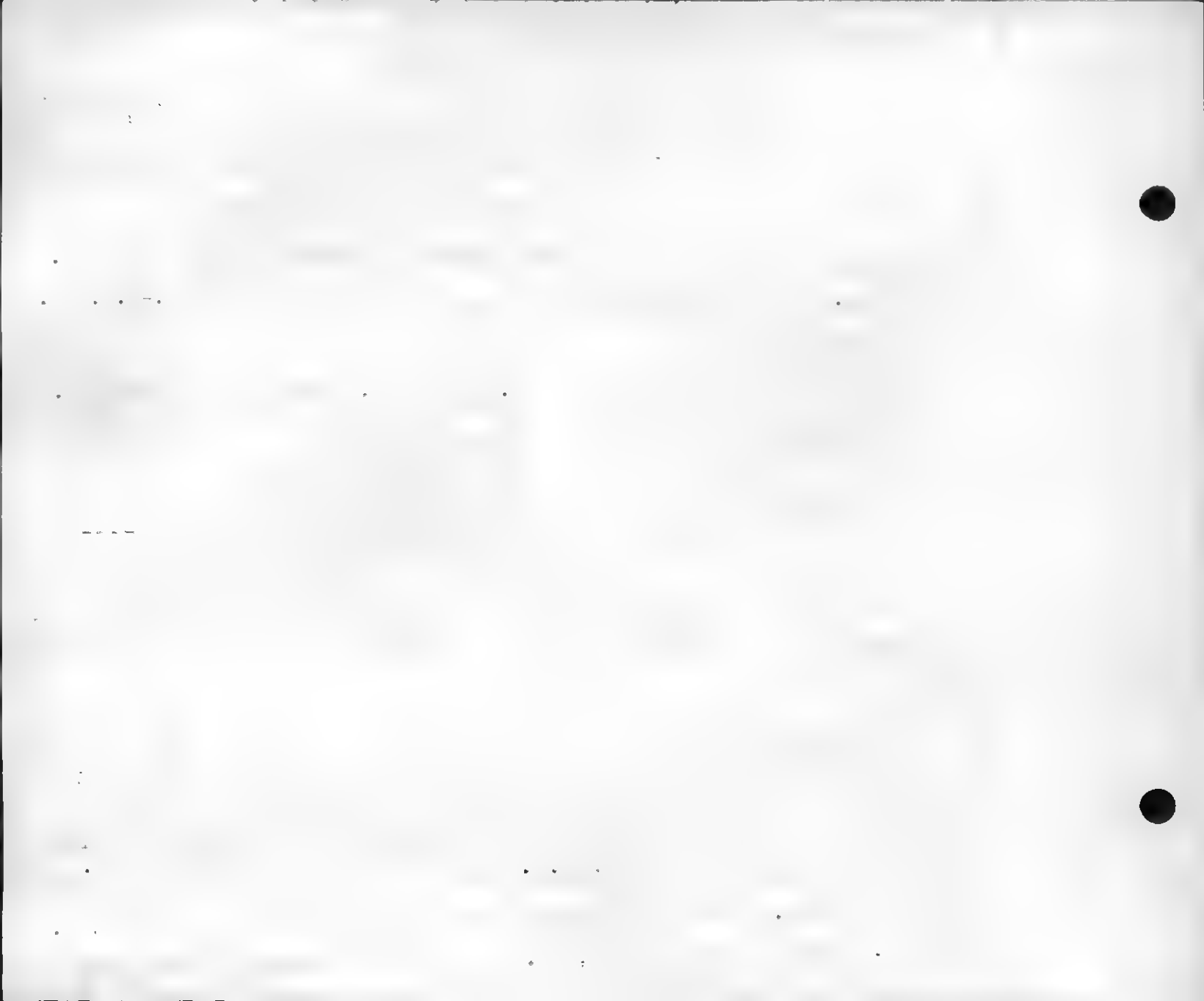
# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-30. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16770		16783			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED NAME (Type or Print)			First William			Middle Russell			Last Stewart			20. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> DEC. 30, 1968		2b. HOUR 3:40 PM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH April, 21, 1884		6 AGE (in years last birthday) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month December Day 30, Year 1968		2d. HOUR 3:10 PM	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Allegany Md						
10. CITY OR TOWN OF DEATH Cumberland				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Painter				12b. KIND OF BUSINESS OR INDUSTRY Self Emp.			
13a. US.JA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Baltimore Ave.-Y.M.C.A.					
14. FATHER'S NAME First Middle Last Russell Stewart					15. MOTHER'S MAIDEN NAME First Middle Last Mary Barnard										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) no			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17 INFORMANT Mr. Richard W. Stewart, Cumberland, Md.					17 ADDRESS Son				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Gastric Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Peptic Ulcer										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour " -----					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 5-6															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED December 30, 1968					
ACTUAL SIGNATURE Benedict Skitarelic			EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Jan. 2, 1969		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City or Town) Cumberland		23e. COUNTY Allegany		23f. STATE Md.		
24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR JAN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
16771		16784										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH @			2b. HOUR			
Audra MYRTLE Taylor						December 31, 1968			9:40 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		Jan. 20, 1894			74 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
W. Va.		U. S. A.				Allegany County Md						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (If retired, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland			Allegany County Infirmary			SEAMSTRESS Retired: Factory			Indrgarment			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Allegany		Cumberland				723 Lafayette Street			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
Thomas F. Allen			Mary E. Michaels									
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT							
			220-26-7545		P.O. Box 599, Cumberland, Md. Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4120</u> <u>Bronchopneumonia, Bilateral</u> <u>4 days</u>												
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST												
(b) <u>Chr. A3 - Hyp. C.V.D.</u> <u>many years</u>												
(c) <u>Diabetic A.S.</u> <u>many years</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
<u>4</u> <u>Diabetes mellitus - Compensated</u> <u>11/68</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No			City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/30/</u> 19 <u>65</u> , to <u>Dec. 31, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec. 31, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			22c. DATE SIGNED									
<u>John A. Topper MD</u>			<u>1-4-69</u>									
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS									
<u>John A. Topper MD</u>			<u>Memorial Hosp. Cumberland, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Type)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
<u>Burial</u>			<u>1/4/69</u>		<u>Greenway Cemetery</u>		<u>Berkeley Springs Morgan W. VA.</u>					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
<u>H. Wayne George Cumberland, Md.</u>						<u>Jan 8 1969</u>			<u>Charles Judge</u>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>16772</div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>16772</div> <div>16785</div> </div>												
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR			
LUCINDA			MAE TRIMBLE			<input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year DEC 16 68			215A			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years)	7. UNDER YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR	
FEMALE	WHITE	APRIL 4, 1906	62	MONTHS DAYS		HOURS MIN		DEC 16 1968			215A	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.			
PENNSYLVANIA		U. S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		ALLEGANY						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done most of working life)			12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND			BIOVA SACRED HEART HOSPITAL			HOUSEWIFE			HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MARYLAND			ALLEGANY		MT. SAVAGE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD# 1 BOX 153 MT SAVAGE			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO			
FORREST			WEYANT			AMANDA			GEORGE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS			
NO			NONE			FRANCIS A. TRIMBLE			RFD# 1 BOX 153 MT SAVAGE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:										SUFFER		
IMMEDIATE CAUSE (a) 4104												
DUE TO, OR AS A CONSEQUENCE OF												
CORONARY OCCLUSION												
(b) CORONARY SCLEROSIS												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
4201												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
CAUSE OF DEATH		HOUR A.M. P.M.										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED				
Benedict Skitarelic								DEC 16, 1968				
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				ADDRESS (Street, city, town, or county)				
BENEDICT SKITARELIC, M.D.				GUMBERLAND, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		County		State		
BURIAL		18 DEC 68		REST LAWN MEMORIAL PARK		LAVALLE		ALLEGANY		MARYLAND		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
H. LEE SILCOX				DEC 19 1968				Charles Judge				
404 DECATUR STREET CUMBERLAND MD												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16786

1. DECEASED-NAME (Type or print) <b>HENRY</b>		First <b>A.</b>		Middle <b>WALKER</b>		Last		2a. DATE OF DEATH 12 Month 7 Day 68 Year		2b. HOUR 7:40A	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH 10/21/96		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY CO.</b> Md					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>SACRED HEART HOSP.</b>		12a. US. At OCCUPATION (Kind of work done during most of working life, even if retired) <b>QUEEN CITY DAIRY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DAIRY</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INS. DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>307 FRANKLIN STREET</b>			
14. FATHER'S NAME First <b>HARRY</b>		Middle <b>WALKER</b>		Last <b>ELLA</b>		15. MOTHER'S MAIDEN NAME First <b>MC CAFFREY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>214 05 6478</b>		17. INFORMANT <b>PATIENT'S HOSPITAL CHART</b> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1621</b> <u>cochexia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>concomitant of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 year</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>1 year</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>1632</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-5-68</u> , 19 <u>68</u> , to <u>12-7</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>12-7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>L. Brings</u>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>12-7-68</u>					
22d. PHYSICIAN'S NAME (Type) <b>DR. LEWIS BRINGS</b>		22e. ADDRESS <b>57 GREENE STREET, CUMBERLAND, MD. 21502</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/10/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes Cemetery</b>		23d. LOCATION (City or Town) <b>Cumberland</b>		(County) <b>Allegany</b>		(State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>KIGHTS FUNERAL HOME, 309 DECATUR ST., CUMBERLAND, MD. 21502</b>		25a. REC'D BY REGISTRAR <b>DEC 13 1968</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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VR A15 (4)  
30M REV. 1/68

<div style="display: flex; justify-content: space-between;"> <span>16774</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>16787</span> </div>											
1. DECEASED-NAME (Type or print) First Middle Last <b>WILLIAM P. WENDT</b>				2a. DATE OF DEATH Month Day Year <b>12 68</b>				2b. HOUR MIN <b>12:45 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>12/2/98</b>				6. AGE (In years lost birthday) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY CO., Md.</b>					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>BRANCH MANAGER</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRIAL BISCUIT CO.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>817 GEPHART DRIVE</b>			
14. FATHER'S NAME First Middle Last <b>WILLIAM F. WENDT</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>CLARA WARNICK</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>174 01 7500</b>		17. INFORMANT Address <b>PATIENT'S HOSPITAL CHART</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if only, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>coronary sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4001</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>11-24</u> , 19 <u>68</u> , to <u>12-2</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-1</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <u>L. Brings</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>12-3-68</u>			
22d. PHYSICIAN'S NAME (Type) <b>DR. LEWIS BRINGS</b>				22e. ADDRESS <b>57 GREENE ST., CUMBERLAND, MD. 21502</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/6/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Graceland Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>New Castle, Lawrence, Penna.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Philip B. Wendt 121 Memorial Ave., Cumb., Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 6 1968</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MEDICAL CERTIFICATION

1. *Chlorophyll a* (Chl *a*)

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10-15-69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
JAMES		H.		WHEELER				12 Month 23 Day 68 Year		8:35 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		4/25/05		63 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CIT ZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		USA				ALLEGANY				Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during last year or even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		SACRED HEART HOSPITAL		MEAT CUTTER		FOOD MKT.					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS-OR CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		ALLEGANY		CUMBERLAND				120 INDEPENDENCE ST.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
EDWARD		WHEELER						ANNA ROWAN WHEELER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or NO (own)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
NO		214 05 8929		SACRED HEART HOSPITAL		900 SETON DRIVE CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cachexia										2 mos	
DUE TO, OR AS A CONSEQUENCE OF											
(b) Generalized Carcinomatosis										1 yr.	
DUE TO, OR AS A CONSEQUENCE OF											
(c) Carcinoma of Hypopharynx										6 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
147X none											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1966, to 12/23, 1968, that (I) (we) last saw the deceased alive on 12/23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
		12/24/68		DR. J. A. PAGAN		1068 NATIONAL HIGHWAY CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Buried		Dec. 26, 1968		St. Mary's Cemetery		Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
SCARPELLI FUNERAL HOME - 108 VA. AVENUE		CUMBERLAND, MARYLAND		DATE JAN 3 1969		Charles Judge					



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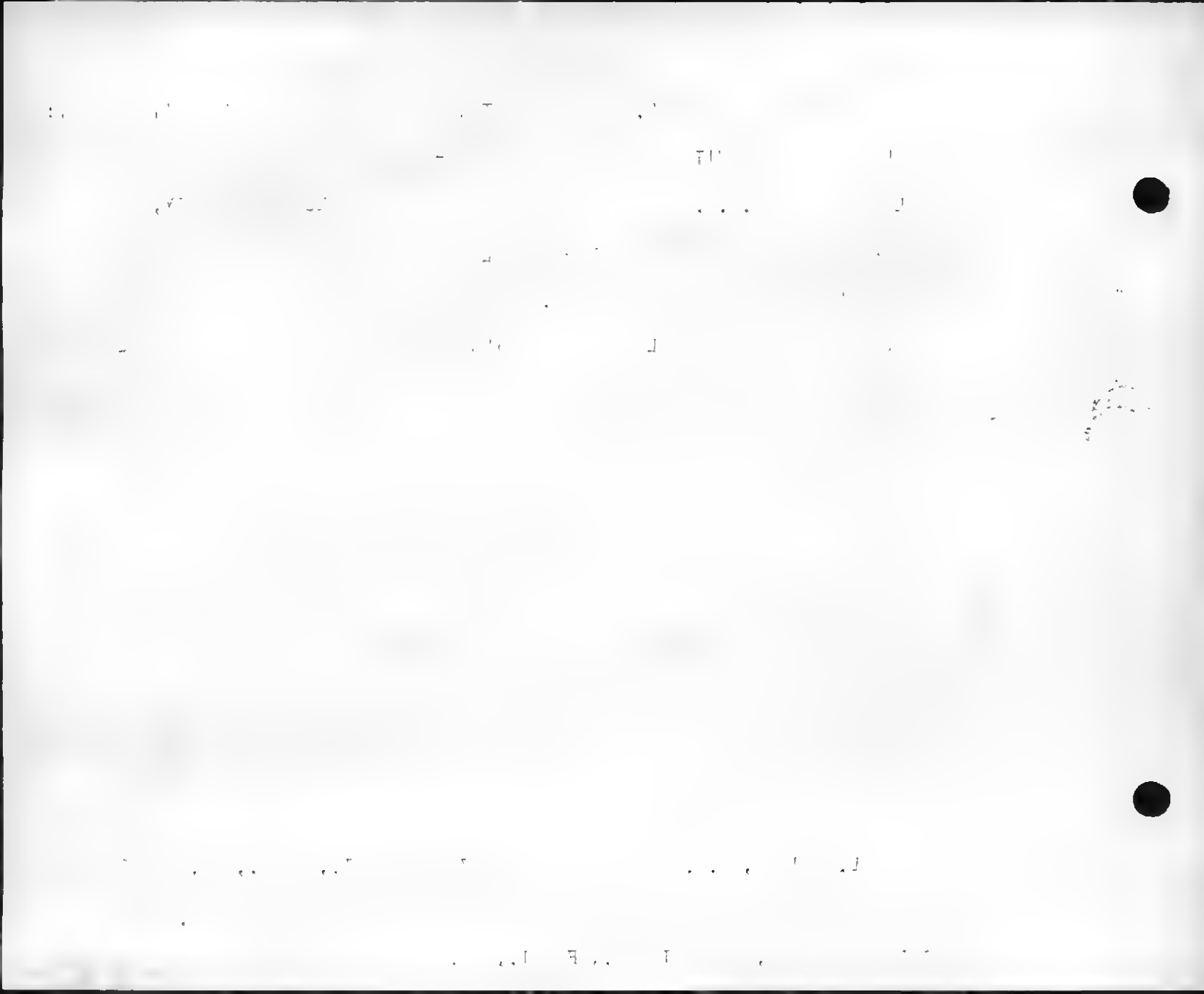
30M REV 1-7-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

16776

16789

1 DECEASED NAME (Type or print) <b>MARY</b>		First <b>MARY</b>		Middle <b>F.</b>		Last <b>WHORTON</b>		2c. DATE OF DEATH Month <b>12</b> Day <b>11</b> Year <b>68</b>			2b HOUR <b>11:45</b>	
3. SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>03-06-93</b>			6 AGE (In years lost birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS <b>75</b> DAYS <b>75</b>		IF UNDER 24 HRS HOURS <b>75</b> MIN <b>75</b>	
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>ALLEGANY COUNTY, Md.</b>						
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>MT. SAVAGE</b>		13c CITY OR TOWN <b>MT. SAVAGE</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
14. FATHER'S NAME First <b>LEVI</b> Middle <b>BLANK</b> Last <b>BLANK</b>				15 MOTHER'S MAIDEN NAME First <b>(WILHELM) FANNIE</b> Middle <b>BLANK</b> Last <b>BLANK</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>214-01-0110A</b>		17 INFORMANT <b>HOSPITAL RECORD</b>								
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>apoplectic stroke</b> <b>1120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>cardio renal vascular disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>1 1/2 hr</b> <b>2 3/4 hr</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE OR CONDITION GIVEN IN PART 1 (a) <b>44-1-X</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. <b>19</b> Month <b>12</b> Day <b>11</b> Year <b>68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No <b>57</b> City or Town <b>MT. SAVAGE</b> County <b>MD.</b> State <b>MD.</b>								
22a I certify that (I) (this hospital) attended the deceased from <b>11-29-1968</b> to <b>12-11-1968</b> , that (I) (we) lost saw the deceased alive on <b>12-11-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE <b>L. BRINGS, M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-12-68</b>						
22d PHYSICIAN'S NAME (Type) <b>L. BRINGS, M.D.</b>		22e ADDRESS <b>57 GREENE ST., CUMB., MD. 21502</b>										
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE <b>12-14-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>ST. PATRICKS CEMETERY</b>		23d. LOCATION (City or Town) <b>MT. SAVAGE, MD.</b> (County) (State)						
24 FUNERAL DIRECTOR <b>DURST FUNERAL HOME, 57 FROST AVE., BROST., MD.</b>		ADDRESS		25a REC'D BY REGISTRAR <b>DEC 16 1968</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>						



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			20. DATE KNOWN OF DEATH			2b HOUR		
Rose C. Willetts						Month Day Year			10a M		
3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER YEAR MONTHS	8 YEAR DAYS	9 IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD			2d HOUR	
Female	White	May 23, 1903	65 YRS				Month Day Year			10a M	
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Md.			USA						Allegany Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
LaVale			137 National Highway			Housewife			Own Home		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md.			Allegany			LaVale			137 National Highway		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
Peter H. Wagner			Margaret (Sherry)								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
No			None			J. William Willetts			137 National Highway LaVale, Md.		
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										SUDDEN	
IMMEDIATE CAUSE (a) CORONARY OCCLUSION											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) CORONARY SCLEROSIS											
DUE TO, OR AS A CONSEQUENCE OF											
(c)										1	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION											
19b CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION Street or RFD No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			BENEDICT SKITARSLIC			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			December 13, 1968		
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town or county)		
						CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			12/16/68			Frostburg Memorial B			Frostburg Allegany Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
William G. Kight			Cumberland, Md.			DEC 20 1968			Charles Judge		

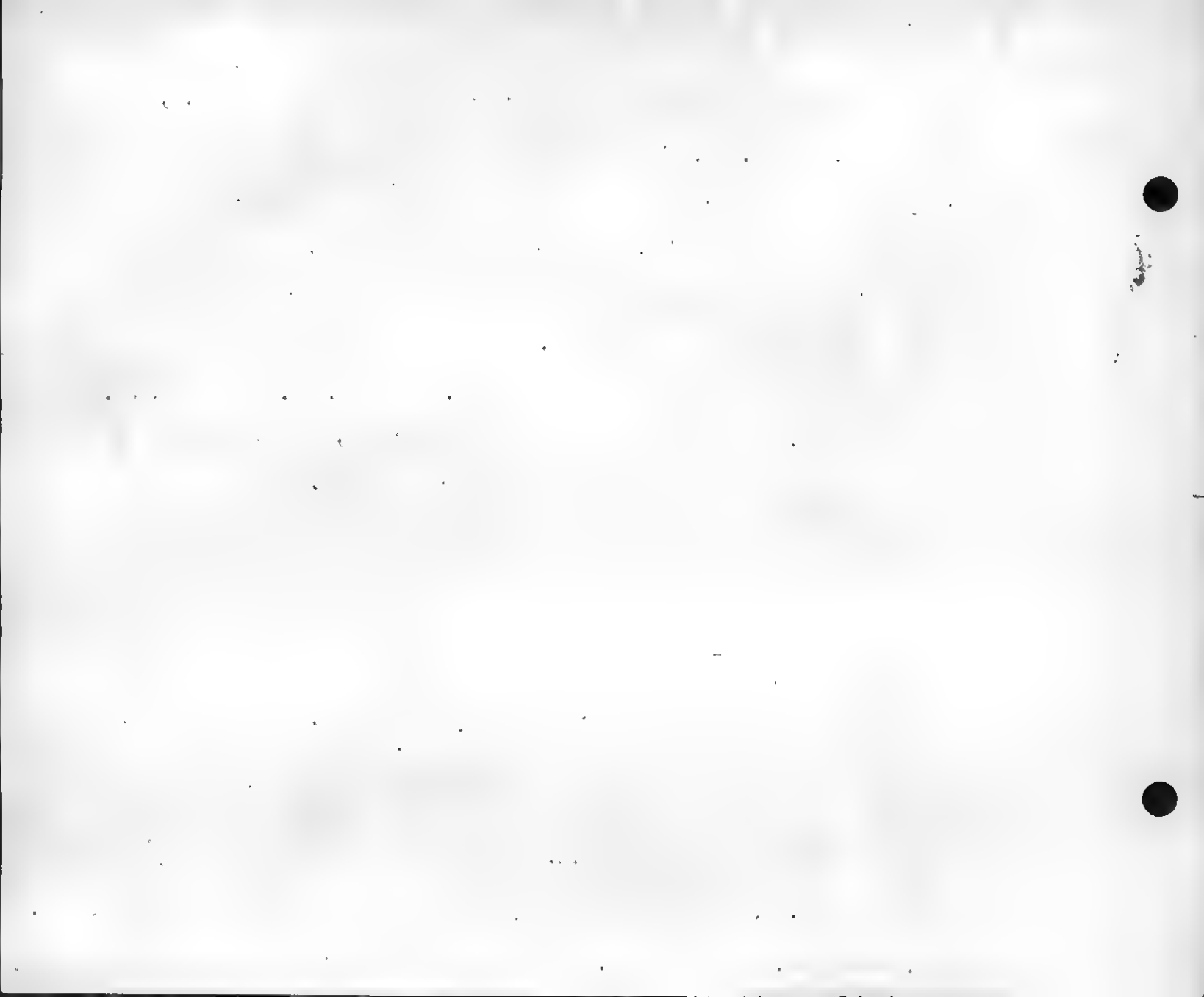


FOR STATE  
HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH MATED			2b. HOUR		
Karen Jane Willison						DEC. 6, 1968			5:20p M		
3 SEX	4. RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	Mar. 25, 1960	8 YRS					DECEMBER 6, 1968		5:30p M	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			U S A						Allegany Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Frostburg			Miner's Hospital---DOA			Student - 3rd Grade			Frost Elementary School		
13a. USUAL RESIDENCE (Where deceased lived, if institution on residence before adm ssion) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY (If Yes)		
Maryland			Allegany			Frostburg			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
James Nelson Willison, Jr			Dorothy Elaine Baker			19 Park Avenue					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			17. ADDRESS		
No						James N. Willison, Jr.			Frostburg, Md.		
18. CAUSE OF DEATH (Enter any one cause per line for (a) (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 514.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Skull Fracture, Fractured Neck										Minutes	
(Struck by Automobile)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 812+											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
5420 P.M. Dec. 6 19 68				Struck by Vehicle (Pedestrian)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
Street				Corner of Linden & Water Sts. Frostburg, Alleg. Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE: <i>Benedict Skitarelic</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						ASS STANT MED. CAL. EXAMINER <input type="checkbox"/>					
						22b. DATE SIGNED					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> December 6, 1968					
						ADDRESS (Street, city, town, or county) Cumberland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Dec. 9, 1968			Hillcrest Burial Park			Near Cumberland Alleg. Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR					
John J. Hafer, Jr.						25b. REGISTRAR'S SIGNATURE					
John J. Hafer, Jr. 230 Balto Ave. Cumberland, Md.						DATE DEC 10 1968 <i>Charles Judge</i>					

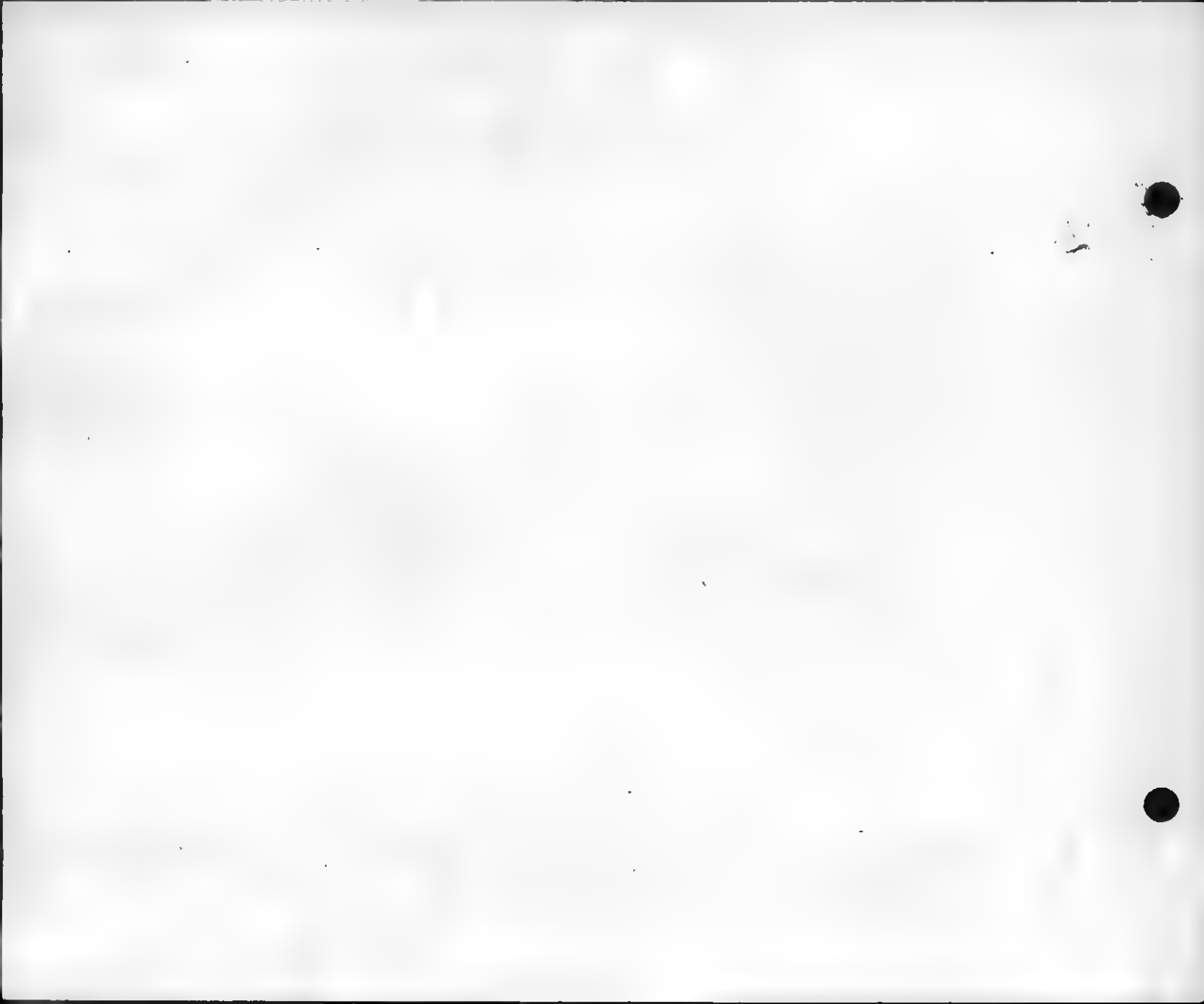


**FOR STATE  
HEALTH DEPT.**

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages read with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 5 Film 108 1/6/69 kk DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16779		16792	
1. DECEASED-NAME (Type or Print) First: <b>SHIELDON</b> Middle: <b>B.</b> Last: <b>WILLISON</b>						2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year <b>12/23/68</b>			2b. HOUR <b>6 A M</b>				
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>JAN. 25, 1905</b>		6 AGE (in years last birthday) <b>63 YRS</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year <b>12 23 19 68</b>		2d. HOUR <b>7A M</b>	
7a. BIRTHPLACE (State or foreign country) <b>PENNA.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH <b>ALLEGANY</b>				
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DOA MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>LABORER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>VARIOUS</b>		
3a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>PENNA.</b>				13b. CITY OR TOWN <b>REDFORD</b>		13d. INSIDE CITY LIMITS? <b>YES</b>		13e. STREET AND NUMBER <b>RT. 2, LAKE GORDON ROAD</b>					
14. FATHER'S NAME First: <b>RAY</b> Middle: <b>WILLISON</b> Last: <b>WILLISON</b>						15. MOTHER'S MAIDEN NAME First: <b>LORA</b> Middle: <b>BARNES</b> Last: <b>BARNES</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>						16b. SOCIAL SECURITY NO <b>207 10 9366</b>		17. INFORMANT <b>ROUTE 2, RAY WILLISON, CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-----</b> (c) <b>-----</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Hypertensive cardiovascular disease</b>													
19a. DATE OF OPERATION <b>12/2</b>						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town. County. State.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>12/23/68</b>					
EXAMINER'S NAME (Type) <b>BENELECT SKITARELIC, M.D.</b>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <b>ROUTE 2, CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>DEC. 26, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>UNION GROVE CEMETERY</b>				23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND, MD.</b>			
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>						ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REG STRAR <b>DEC 30 1968</b>		25b. REG STRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
16780					16793						
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR			
First MIDDLE Last HUGH W. WILSON					DECEMBER <sup>th</sup> 15, 1968			10:00 PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
MALE		WHITE		3-18-01			67 YRS.				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND			U. S. A.				ALLEGANY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL HOSPITAL			RETIRED Paymaster			Paper Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND					ALLEGANY		LUKE		303 FAIRVIEW ST.		
14. FATHER'S NAME First MIDDLE Last					15. MOTHER'S MAIDEN NAME First MIDDLE Last						
ROBERT WILSON					SARAH WATSON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO					216-07-9366		MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial failure</i>										1 hr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>5609</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Massive Pulmonary Infarct</i>										1-2 hr.	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>5705</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
<i>P.O. status (release of intest obstr)</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
12/13/68			Small bowel obstr.								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <i>Dec 15</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dr. A. J. Mirkin MD.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED Dec. 15, 1968					
22d. PHYSICIAN'S NAME (Type) DR. A. J. MIRKIN						22e. ADDRESS 115 S. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Dec. 19, 1968		Philos Cemetery			Westernport Alleg. Md.			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE		
W. Harold Fredlock, Jr. Piedmont, W. Va.						DEC 23 1968			<i>Walter Judge</i>		

10789  
DECEMBER 12, 1963 10:00  
WILSON  
HILL

WHITE  
3-18-01  
ALBANY

CHURCHLAND  
WILSON  
SEE PAGE 150 ST.

WILSON  
WILSON  
CHURCHLAND, N.Y.

CHURCHLAND, N.Y.  
111 S. EIGHTH ST.  
CHURCHLAND, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="text-align: center;"> <b>16781</b>  <div style="display: flex; justify-content: space-between;"> <div> <p>1</p> </div> <div> <p><b>MARYLAND</b> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201</p> </div> <div> <p><b>16794</b></p> </div> </div> <p><b>CERTIFICATE OF DEATH</b></p> </div>																	
1. DECEASED-NAME (Type or print)			First <b>BERNARD</b>			Middle <b>F.</b>			Last <b>WOODS</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>09</b> Year <b>68</b>			2b. HOUR <b>9:25</b>		P <b>M</b>
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>07-16-99</b>			6. AGE (In years last birthday) <b>69</b> YRS.			IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b>		IF UNDER 24 HRS. HOURS <b>00</b> MIN. <b>00</b>			
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ALLEGANY</b> Md.								
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Tire Builder</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>KEELY TIRES</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>ALLEGANY</b>			13c. CITY OR TOWN <b>ELLERSLIE</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>ELLERSLIE, MD. 21529</b>					
14. FATHER'S NAME First <b>WILLIAM</b> Middle <b>WOODS</b> Last <b>WOODS</b>			15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>MC</b> Last <b>PARTLAND</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>214-07-0080</b>			17. INFORMANT <b>PTS. HOSP. CHART</b> <b>SACRED HEART HOSP</b>			Address <b>CUMB., MD. 21502</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Non-fatal cardiac arrhythmia</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (this hospital) attended the deceased from <b>12-5</b> , 19 <b>68</b> , to <b>12-9</b> , 19 <b>68</b> , that (we) last saw the deceased alive on <b>12-9</b> , 19 <b>68</b> , and that in (our) (my) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Richard W. Trevaskis Jr.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED <b>Dec 11, 1968</b>																	
22d. PHYSICIAN'S NAME (Type) <b>RICHARD W. TREVASKIS JR., M.D.</b> 22e. ADDRESS <b>200 BALTO AVE., CUMBERLAND, MD. 21502</b>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Dec. 13, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>								
24. FUNERAL DIRECTOR <b>SCARPELLI FUNERAL HOME</b>			ADDRESS <b>108 VIRGINIA AVE., CUMBERLAND, MD. 21502</b>			25a. REC'D BY REGISTRAR <b>DEC 16 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								

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## CONCLUSION

C. J. C.

Y. H. CHEN

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STATE OF NEW YORK, SENATE, JANUARY 11, 1906.